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Medicaid Program Evaluation

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MEDICAID ELIGIBILITY:
ANALYSIS OF TRENDS AND
SPECIAL POPULATION GROUPS

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Department of Health and Human Services
Health Care Financing Administration
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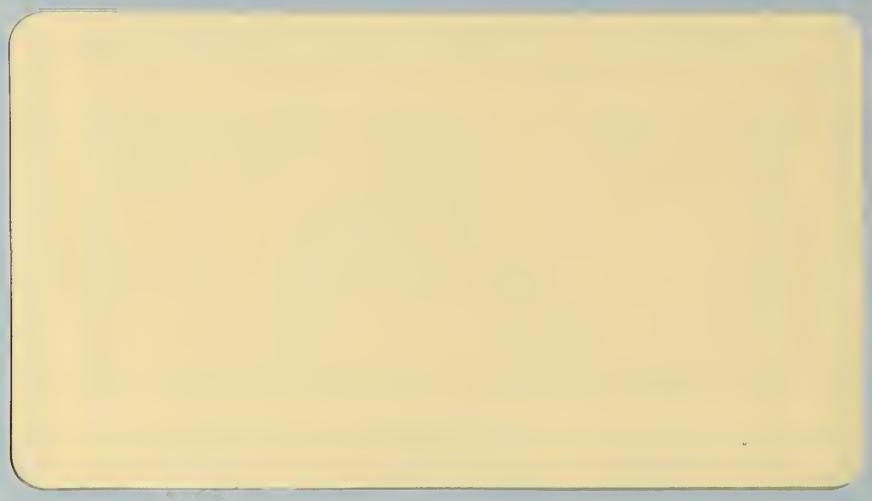

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PREFACE

The Medicaid program, which finances health care for over 20 million needy Americans, has undergone major changes since 1981. Beginning with the Omnibus Budget Reconciliation Act of 1981 (OBRA), Congress gave the States much more flexibility to change basic parameters of the program, including which groups of people are served, which services are provided, how doctors, hospitals, and nursing homes are paid, and how care can be organized in innovative ways.

The Medicaid Program Evaluation addresses the implementation and impact of selected changes in the Medicaid program to provide knowledge for policy assessment and future legislative change. It is focused on selected issues and includes nine major study areas:

- Federal Financial Participation
- Inpatient Hospital Reimbursement
- Eligibility
- Case Management
- Home and Community-Based Waiver Programs
- Cost-Sharing
- Financial Incentives for Family Care
- Medicare PPS Effects on Medicaid and
- Synthesis.

Together these studies are intended to describe how recent changes have been implemented and analyze what their effects have been for program services and costs.

This paper examines program trends related to eligibility policy--an area of ongoing concern in understanding the dynamics of the Medicaid program. It is the sixth in a series of eligibility-related research papers. It focuses on trends in Medicaid eligibility over the last decade, as well as analysis of four special population groups, including Ribicoff children, disabled children, ICF-MR recipients and the disabled over age 65 years.

ACKNOWLEDGEMENTS

The authors are indebted to Gerald Adler of the Office of Research in HCFA for his ongoing support of research related to Medicaid eligibility policy and its impact on program trends. We also wish to thank Gabrielle Lupo of the Office of Management and Budget for her help in identifying the special population groups for study. David Baugh, also of the Office of Research in HCFA, assisted in obtaining the cooperation of the States participating in the Tape-to-Tape project (California, Georgia, Michigan, and New York). We appreciate the willingness of the Tape-to-Tape States to share their data. Finally, we would like to express our appreciation to James Bell Associates, the prime contractor, for their cooperation in making this project happen.

Review of the draft final report was provided by Gerald Adler and David Baugh of HCFA's Office of Research, State officials involved in the Tape-to-Tape project, and Felicity Skidmore, editor for the overall Medicaid Program Evaluation Synthesis report. Kipp Gabriel of SysteMetrics provided administrative support for the project.

Chapter 2 was jointly authored, with Brian Burwell taking the lead. Marilyn Rymer was responsible for Chapters 1, 3 and 4, while Brian Burwell wrote Chapters 5 and 6.

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EXECUTIVE SUMMARY

Eligibility is the gatekeeper to the Medicaid program. Thus, an understanding of eligibility policy and its impacts is critical to managing Medicaid. This report, Medicaid Eligibility: Analysis of Trends and Special Population Groups, responds to several important eligibility-related research concerns. It provides a summary of trends in Medicaid eligibility over the last ten years, as well as findings regarding four special population groups of interest--Ribicoff children, disabled children, ICF-MR recipients and the disabled over age 65.

How have State eligibility policies related to Medicaid changed over the last ten years?

Two important developments have shaped Medicaid eligibility policy over the last decade. First, income levels used for the AFDC program (and thus Medicaid) have declined substantially in real terms (-30% in the median State since 1975) while the levels used for the aged and disabled have increased significantly (10% in the median State), largely due to the indexing of Federal SSI standards. In a sense, the setting of AFDC and SSI income levels may not be perceived as Medicaid eligibility policy decisions. Nevertheless, since four out of five Medicaid recipients are eligible for Medicaid because they receive AFDC or SSI benefits, these financial criteria are pivotal to Medicaid eligibility determination, and are therefore important developments in eligibility policy.

Second, as a result of Federal legislative initiatives, requirements for AFDC cash assistance and Medicaid (independent of State payments standards for AFDC) have become more restrictive for working poor families and older children. At the same time, Federal law has mandated States to expand their Medicaid coverage of some groups of non-cash children and families, and provided increased flexibility to States to expand their coverage of other optional groups of non-cash families and children, especially Ribicoff

children.[1] In effect, eligibility for Medicaid through the AFDC cash program has been made more restrictive, while eligibility for Medicaid through the non-cash groups has been enhanced.

What has been the impact of Medicaid eligibility changes on Medicaid enrollment? How have changes in Medicaid eligibility policy affected Medicaid's coverage of the poverty population?

Between 1975 and 1985, the total number of Medicaid recipients changed less than 1%, moving from 20.3 million to 20.2 million. However, there were significant changes in the composition of the Medicaid recipient population, especially relative to the size and composition of the poverty population.

The real decline in the AFDC payment levels between 1975 and 1985 has had a major impact on limiting Medicaid enrollment. Although the number of children in poor families increased dramatically between 1975 and 1985, the number of AFDC cash recipients was constant. Thus, Medicaid covered a declining proportion of children in poverty over this period. Federal efforts to expand Medicaid coverage of non-cash AFDC-related families and children were moderately successful. The non-cash AFDC group grew by about 50% over the ten year period. However, it still accounted for only 10% of Medicaid recipients in 1985.

Much of the growth of children in poverty occurred in two-parent families. Although the number of States offering full Ribicoff coverage has grown, study results showed that only about 2.2 million of the 6.2 million poor children in two-parent families were enrolled in Medicaid in 1985, either under the Ribicoff children or AFDC-U coverage options. The problem is that for the children to become eligible for Medicaid, their families are still required to meet the AFDC (or medically needy) financial criteria. Thus, increases in the number of children in poverty over the period from 1975 to 1985 were not reflected in Medicaid enrollment trends, either through the coverage of AFDC-related recipients or children in two-parent poor families.

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[1]Ribicoff children are named after the Connecticut Senator who sponsored the legislation creating this Medicaid coverage group.

In spite of the increases in Federal SSI levels between 1975 and 1985, the number of elderly Medicaid recipients has declined, largely due to the improved economic status of the aged. However, Medicaid's coverage of the elderly poor has not eroded over time. The number of disabled Medicaid recipients under age 65 has increased modestly.

What impact have Medicaid eligibility changes had on expenditures?

Although poor families and children comprise a growing proportion of the poverty population, the proportion of Medicaid resources directed to them is declining. In 1975, 35% of Medicaid expenditures were for medical services provided to AFDC-related families. Ten years later, AFDC-related recipients accounted for only 24% of Medicaid costs. This redistribution in expenditures is due to the higher costs of serving the aged and disabled. The average annual cost per aged and disabled recipient increased at an annual compound rate of growth of 4.7% and 4.0% respectively in real dollars. For AFDC-related children and adults, average annual costs per recipient declined slightly in real terms over the ten year period.

What have been the enrollment patterns for four special groups of interest?

Ribicoff Children. Ribicoff children are poor children whose families meet the financial, but not the categorical, requirements of the AFDC program. Generally speaking, they are children in two-parent poor families. For many years, States have had the option of covering these children through age 20 under Medicaid. In addition, recent Federal legislation has mandated the coverage of younger Ribicoff children in all States and provided greater flexibility to States to cover all Ribicoff children through age 18. Little information has been available to policymakers to describe the number of Ribicoff children or their Medicaid utilization and cost patterns. Since close to half of the children living in poverty are in two-parent families, it is important to understand the effectiveness of Medicaid in reaching this population.

The number of States extending full Ribicoff coverage to children up to age 18 has increased significantly in the last few years, up to 32 States by 1986. However, these expansions have been only modestly effective. Ribicoff

children were estimated to account for about 750,000 children in FY 1985--less than 4% of Medicaid recipients nationwide. Study data suggest that coverage has generally occurred only for children with unusually high medical expenses. As a result, Ribicoff children use more Medicaid services on average and cost more than AFDC children. The average annual cost for a Ribicoff child ranged from $971 to $1239, compared to $367 to $556 for AFDC children among the study States (1982-1983). Also significant, most Ribicoff expenditures were for infants and older teenagers (15-20 years). These two age groups accounted for 62% to 77% of Ribicoff expenditures among the study States. Study results suggest that Ribicoff coverage is focused on maternal and high cost infant services, not routine care for children of all ages.

Disabled Children. Disabled children only became eligible for Medicaid with the implementation of the SSI program in 1974. A few States have elected not to extend Medicaid coverage to disabled children. In these States, disabled children generally can qualify for Medicaid only through AFDC or Ribicoff children eligibility provisions. No data are available at the Federal level which separate disabled children from disabled adults with regard to Medicaid, thus policymakers have not had information which would assist them in understanding the impact of this coverage group on Medicaid.

The number of disabled children receiving SSI payments was 346,931 in 1984. Disabled SSI children are increasing at a slightly greater rate than the adult disabled SSI population, with an annual growth rate of about 5%. For the study States, children were found to account for 7%-12% of the total Medicaid disabled and from 1%-2% of total Medicaid enrollees. They accounted for 3% to 6% of expenditures. Generally, the annual cost per disabled child was greater than the cost for adult disabled enrollees. Much of the difference could be attributed to the greater expense for long-term care for disabled children. Over half of the Medicaid expenditures for disabled children went to long-term care. Although about 10% of disabled children and disabled adults were institutionalized during the year, children were much more likely to be in the more expensive ICF-MR facilities. Another factor is that disabled children are generally not eligible for Medicare, unlike many of the adult disabled population.

ICF-MR Recipients. ICF-MR recipients are one of the highest cost populations in Medicaid. In FY 1985, the 143,846 individuals receiving care in ICF-MRs accounted for 0.7% of all recipients, but 12.7% of expenditures. Total costs exceeded $4.7 billion, for an average cost per ICF-MR recipient of $32,960.

The ICF-MR program grew at an extremely rapid rate in the late 1970's, as States moved to certify their public institutions for the mentally retarded as ICFs-MR, in order to secure Federal financial participation for the cost of operating these facilities. Since 1982, however, the number of ICF-MR recipients has stabilized. There has also been a shift from large-scale, publicly-operated facilities to small-scale, privately-operated facilities. By 1985, 10% of ICF-MR recipients were in facilities with less than 16 beds, a ten-fold increase over an eight year period. ICF-MR expenditures have also stabilized, increasing only slightly higher in recent years than Medicaid expenditures as a whole. Person-based data showed that ICF-MR recipients are; in general, low utilizers of Medicaid services other than ICF-MR care. ICF-MR utilization and expenditure rates vary enormously across States. States differ significantly in the degree to which they have used the ICF-MR program as a financing source for their residential care systems for the mentally retarded. Daily per diems for ICF-MR care also vary from less than $50 per day in some States to over $200 per day in others.

Disabled over Age 65. Analyses of aged and disabled Medicaid recipients are confounded by the fact that a growing proportion of recipients classifed as "disabled" by States are 65 years of age or older. The format in which States report Medicaid data does not allow HCFA to analyze the disabled population over age 65.

Study data showed that those over age 65 were from 12% to 23% of disabled recipients among the study States. Because such a small percentage of disabled recipients over age 65 were users of long-term care, they cost considerably less than the average aged Medicaid recipient. They also cost less than the non-elderly disabled. Study results suggest that counting disabled Medicaid recipients over 65 as aged rather than disabled would increase the aged Medicaid population by 19.8%, but expenditures for the aged by only 9.2%.

Chapter 1

INTRODUCTION

The impact of eligibility decisions on Medicaid enrollment and costs is a source of continued concern to Federal and State policymakers. In response to this concern, this report is the sixth in a series of eligibility-related papers within the Medicaid Program Evaluation project. It addresses a need for better information in several areas of eligibility policy.

First, the report provides an analysis of eligibility trends over the last decade (1975-1985). With the advent of OBRA in 1981, Federal legislative changes related to Medicaid eligibility were made almost annually. The trends analysis covers these recent changes, as well as the ongoing eligibility decisions made by States over this period to determine what effect they have had on Medicaid operations. The analysis is intended to help policymakers understand which groups of Medicaid recipients have increased and which groups have declined over the last decade and why, especially in light of changes in the composition of the poverty population over the same time period.

Second, the report provides a more detailed examination of four eligibility groups of interest:

- Ribicoff Children.[1] Ribicoff children are poor children whose families meet the financial, but not the categorical, requirements of the AFDC program. Generally speaking, they are children in two-parent poor families. States have for many years had the option of covering these children through age 20 under Medicaid. In addition, recent Federal legislation has mandated the coverage of younger Ribicoff children in all States. Little information has been available to policymakers to describe the characteristics of Ribicoff children in using the Medicaid program. This report uses recently available data to describe the Medicaid patterns of Ribicoff children in three States and to compare them to AFDC children.

[1]Ribicoff children are named after the Connecticut Senator who sponsored the legislation creating this Medicaid coverage group.

- Disabled Children. Disabled children only became eligible for Medicaid with the implementation of the SSI program in 1974. No information is available at the Federal level to separate disabled children from disabled adults with regard to Medicaid. This report uses recently available data to describe the enrollment, utilization and expenditure experience of disabled children in four States and to compare the Medicaid patterns of disabled children with those of disabled adults.

- ICF-MR Recipients. ICF-MR recipients are one of the highest cost populations in Medicaid. In FY1985, the 148,846 individuals receiving care in ICF-MRs acccounted for 0.7% of all recipients, but 12.7% of Medicaid expenditures. This report uses a variety of data sources to analyze trends in ICF-MR enrollment and costs.

- Disabled Over Age 65. Analyses of the aged and disabled Medicaid populations are confounded by the fact that a growing proportion of recipients classified as "disabled" by States are 65 years of age or older. The format in which States report Medicaid data does not allow HCFA to analyze the disabled population over age 65. This report uses data from the Social Security Administration and four State Medicaid programs to better estimate Medicaid's coverage of the elderly, including those recipients over age 65 classified as disabled.

Methodology

To document how States have changed their eligibility policies, a variety of standard sources were used, including:

- Characteristics of State Plans for AFDC, Office of Family Assistance. 1978-1985;
- State Medicaid Program Characteristics, HCFA, 1982-1984;
- The Medicaid and Medicare Guide from the Commerce Clearing House;
- Catalogue of State Medicaid Program Changes, National Governors' Association;
- Selected Characteristics of State Supplementation Programs, Social Security Administration, 1975-1986;
- The Maternal and Child Health Data Book from the Children's Defense Fund

HCFA 2082 data were the main sources for the estimates of changes in the levels and distribution of Medicaid enrollment and expenditures across groups, supplemented by SSI enrollment information from SSA. Most of the analyses of the special population groups were conducted using HCFA's Tape-to-Tape data set.

Organization of the Report

Chapter 2 presents the study results with regard to Medicaid eligibility trends over the last decade. The chapter begins with an overview of changes in eligibility policies by States and the Federal government. Then analysis is presented of the impacts of these eligibility policies on program enrollment and expenditures. Chapters 3 through 6 present the special population group analyses. Chapter 3 examines the Medicaid experience of Ribicoff children. Disabled children enrolled in Medicaid are the focus of Chapter 4. Chapter 5 is devoted to an analysis of trends in the ICF-MR recipient population. The report concludes in Chapter 6 with a discussion of study results regarding the disabled over age 65.

Chapter 2

TRENDS IN MEDICAID ELIGIBILITY: 1975 to 1985

Eligibility policy is the gatekeeper to the Medicaid program. Eligibility for Medicaid is also incredibly complex. First, eligibility rules for AFDC and SSI cash assistance govern eligibility for about four out of five Medicaid enrollees. Changes in AFDC and SSI eligibility policies, at both the Federal and State levels, have direct impacts on Medicaid program enrollment and expenditures. The number of options which States have in the design of their AFDC cash assistance programs and in how they choose to supplement Federal SSI benefits are many and varied. Second, Federal law mandates States to provide Medicaid coverage for certain groups of persons who are not receiving cash assistance through AFDC or SSI, and allows States considerable flexibility to cover additional groups at their own discretion. Thus, it is difficult enough just trying to understand how eligibility for Medicaid works, without even attempting to figure out how changes in these interacting eligibility rules for AFDC, SSI and Medicaid actually affect program enrollment and expenditure trends.

Nonetheless, an understanding of Medicaid eligibility policy is critical to understanding basic trends in the Medicaid program. This chapter examines the most important developments in Medicaid eligibility policy over the last ten years, and describes the impact which these developments have had on the ability of the Medicaid program to provide medical assistance to poor people. HCFA 2082 data were the main source for the estimates of changes in the levels and distribution of Medicaid enrollment and expenditures across groups, supplemented by SSI enrollment information from SSA.

How Have State Eligibility Policies Changed?

After passage of the legislation creating the SSI program in 1972, Federal provisions affecting Medicaid eligibility were left untouched for many years. Then starting in 1981 and continuing through 1986, Congress amended the

eligibility provisions of Title XIX as part of its budget reconciliation legislation. First OBRA 1981, then TEFRA, DEFRA, COBRA and OBRA 1986 each included changes related to Medicaid eligibility, as documented in Exhibit 2-1.[1] This legislative series both contracted and expanded Medicaid eligibility. Coverage of some Medicaid recipients was cut back in all States, yet at the same time States were provided with additional flexibility to expand their optional eligibility coverage.

Specifically, OBRA (1981) contained provisions which substantially reduced the number of families eligible for AFDC cash assistance. These reductions were mandatory for all States and were primarily aimed at families with earned income and older children (19-20 year olds). OBRA (1981) also mandated uniform resource standards for AFDC cash assistance which affected all types of AFDC families. For some States, these standards represented a loosening of resource limits, but for a greater number of States they caused eligibility requirements to be more stringent. Two years later, DEFRA softened some of the OBRA cutbacks for working families. However, AFDC coverage for working families continues to be more restrictive than it was prior to OBRA 1981.

Although the coverage of AFDC cash recipients was cut back, OBRA (1981), DEFRA, COBRA and OBRA (1986) also mandated some expansions in Medicaid coverage of families and children not receiving AFDC benefits (these recipients are hereafter referred to as non-cash recipients). States were required to provide extended Medicaid coverage to AFDC families in work transition status. States were required to expand their Medicaid coverage of pregnant women, regardless of their eligibility for AFDC. States were also mandated to phase in coverage of children in low-income two parent families (so-called Ribicoff children), if they did not already provide such coverage.

Even more significant, States were given much greater flexibility with regard to their optional coverage of non-cash groups for Medicaid. In particular, States were allowed to implement targeted medically needy programs,

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[1]Much of this discussion of eligibility-related Federal legislation is abstracted from Medicaid Eligibility: A Descriptive Report of OBRA, TEFRA and DEFRA Provisions, and State Responses, Ian T. Hill, Medicaid Program Evaluation Working Paper 5.2, 1984.

Exhibit 2-1

Federal Legislation Affecting Medicaid Eligibility:
1981-1986

OBRA 1981

-Limited gross income for AFDC recipients to 150% of State need standard
-Limited earned income disregards for working AFDC recipients
-Instituted nationwide uniform resource restrictions for AFDC recipients
-Limited AFDC coverage of unemployed parent to "principal earner"
-Restricted AFDC cash assistance for pregnant women with no other children to beginning in 6th month of pregnancy
-Limited AFDC children eligible for cash assistance to those under age 19
-Provided States with greater flexibility in establishing medically needy programs by allowing targeted medically needy coverage for only pregnant women and children
-Provided States with greater flexibility in establishing Ribicoff children coverage by allowing them to set the upper age limit for full coverage at 18, 19 or 20 years

TEFRA 1982

-Provided States with the option of covering disabled children under age 18 living at home if cost of care at home is no more expensive than institutional care
-Provided States with the option of denying Medicaid to SSI-related persons in institutions who dispose of their homes for less than fair market value within two years before applying for Medicaid

DEFRA 1983

-Increased gross income limit for AFDC cash assistance to 185% of State need standard
-Extended the $30 earned income disregard for AFDC from 4 months to 12 months
-Expanded work expense deductions and resource limits for AFDC recipients
-Extended Medicaid coverage for AFDC recipients in work transition status from 4 to 9 months
-Provided States with the option of extending Medicaid for another 6 months to recipients in work transition status
-Required States to extend Medicaid to first-time pregnant women who would be eligible for AFDC if child born and pregnant women in families with principal wage earner unemployed
-Required States to extend Medicaid to all financially eligible children born on or after 10/1/83 up to age 5 in two parent families (so-called Ribicoff children)
-Increased asset limits for SSI recipients for period from 1985 through 1989

COBRA 1986

-Required States to cover under Medicaid all low-income pregnant women meeting AFDC financial requirements
-Provided States with the option of extending Ribicoff coverage to all children under age 5

OBRA 1986

-Provided States with the option of extending Medicaid to all pregnant women, infants and (on an incremental basis) children up to age 5 with incomes up to 100% of the Federal poverty level
-Provided States with the option of extending Medicaid to elderly and disabled poor with incomes up to 100% of the Federal poverty level, providing that some or all of pregnant women, infants and children groups are covered as well
-Provided States with the option of paying under Medicaid only the Medicare cost-sharing obligations of elderly and disabled poor with incomes up to 100% of Federal poverty level, providing that some or all of pregnant women, infants and children groups are covered as well
-Mandated Medicaid coverage for former disabled SSI recipients who have returned to work

Sources: Ian Hill, Medicaid Eligibility: A Descriptive Report of OBRA, TEFRA and DEFRA Provisions and State Responses, M.P.E. #5.2, 1984.

Commerce Clearing House, Consolidated Omnibus Budget Reconciliation Act of 1985 (Report Number 489) and Omnibus Budget Reconciliation Act of 1986 (Report Number 505), Chicago, Illinois, 1986.

covering only pregnant women and children. Restrictions were also loosened regarding the option to fully cover Ribicoff children, allowing States to set the maximum age of coverage at 18, 19 or 20 years, instead of 21 years as previously required. States were given the option of covering AFDC families in work transition status for additional coverage beyond the mandatory period. Most recently, with OBRA (1986), States have been given the option of changing the financial criteria they use to determine Medicaid eligibility for pregnant women, infants and children through age 5 (as well as the aged and disabled). For these groups, a special income eligibility level can be set up to 100% of the Federal poverty level.

Several States have responded to this increased flexibility for families and children, including many which historically have had very restricted Medicaid eligibility policies. By 1986, some 8 States had added targeted medically needy programs for children and pregnant women. Another 12 States had added full Ribicoff coverage for all low-income children under age 18 (Hughes et al, 1986). It is too early to tell how many States will respond to the OBRA 1986 changes allowing use of the Federal poverty level for financial eligibility determination.

Changes in Federal legislation have had only minor effects on the Medicaid eligibility of the aged, blind and disabled over the last few years. In 1980, SSI legislation was amended to prohibit the transfer of assets in order to attain eligibility. TEFRA in 1982 provided States with the option of enacting rules which would deny Medicaid eligibility to nursing home residents who dispose of their homes for less than fair market value within two years before applying for Medicaid. The most recent SSI-related legislation expanded eligibility for the aged and disabled. DEFRA (1984) mandated the indexing of the asset levels used for SSI through 1989. (No such provision was enacted for the AFDC program.) OBRA (1986) made permanent a provision for providing Medicaid coverage to former blind and disabled SSI recipients who are able to work. OBRA (1986) also provided States the option to use up to 100% of the poverty level for Medicaid eligibility determination of the aged and disabled poor, as long as they did so for pregnant women or children as well.

The most important aspect of Medicaid eligibility policy over the last ten years, however, has nothing to do with recent Federal legislation. Rather it

involves the substantial discretion States have always had over the financial criteria used to determine Medicaid eligibility for the AFDC population. Most States have failed to adjust the AFDC financial criteria used to determine eligibility for families and children to keep up with increases in the cost of living, while at the same time the income standards used for the aged, blind and disabled have more than matched the pace of inflation. In effect, cash assistance policies in most States over the last ten years have treated the aged and disabled more favorably than poor children and families, and this policy is reflected in Medicaid eligibility trends.

How did this happen? The key is that the Federal government plays the critical role through the SSI program in setting the financial standards for the aged, blind and disabled while States are totally responsible for setting the AFDC-related standards. By Federal law, the SSI program has always been indexed to increases in the cost of living, but only one State (California) has chosen to index its AFDC standards. Most States also supplement the Federal SSI standard. However, even if a State decides not to increase its SSI supplement, standards for the aged and disabled are raised in each State as a result of the automatic Federal increase.

Exhibits 2-2 and 2-3 document the changes in AFDC and SSI income levels among States. Between 1975 and 1985, AFDC payment standards decreased 30% in the median State in inflation-adjusted dollars. Many single-parent families who would have been financially eligible ten years ago would not qualify for AFDC or Medicaid today. Since State medically needy income levels are required by Federal legislation to be no greater than 133% of the AFDC income level, the financial criteria used in State medically needy programs have also been affected by the decline in AFDC levels.

For SSI, the pattern is reversed. The Federal SSI payment level has increased by 10% in inflation-adjusted dollars from 1975 to 1986. State supplementation levels for SSI have not increased at the same rate. However, the effect in the median State is still that the SSI income level has increased by 10% in real dollars. Thus, some aged and disabled whose income would have prevented them from qualifying ten years ago would now qualify for Medicaid today.

Exhibit 2-2

AFDC Maximum Benefit Level for a Four-Person Family: 1975-1985

State	July 1975	January 1985	Percent change in constant 1985 dollars
Idaho	$344	$344	-49%
West Virginia	249	249	-49%
Kentucky	235	246	-47%
Alabama	135	147	-44%
Hawaii	497	546	-44%
South Dakota	329	371	-42%
Oregon	413	468	-42%
Illinois	317	368	-41%
Iowa	356	419	-40%
Kansas	353	422	-39%
Nevada	230	279	-38%
Virginia	311	379	-38%
North Carolina	200	244	-38%
New Hampshire	346	429	-37%
Wyoming	250	310	-37%
New Jersey	356	443	-37%
Massachusetts	368	463	-36%
Indiana	250	316	-36%
Pennsylvania	349	444	-35%
Tennessee	132	168	-35%
Michigan	399	512	-35%
Delaware	258	336	-34%
North Dakota	347	454	-33%
Oklahoma	264	349	-33%
District of Columbia	297	399	-31%
Arkansas	140	191	-30%
Utah	306	425	-29%
New York	400	566	-28%
Ohio	254	360	-28%
Arizona	197	282	-27%
Texas	140	201	-27%
Louisiana	158	234	-24%
Washington	370	561	-23%
New Mexico	206	313	-23%
Maryland	242	376	-21%
Wisconsin	403	636	-20%
Connecticut	403	636	-20%
Minnesota	385	611	-19%
Colorado	264	420	-19%
Georgia	153	245	-18%
Florida	170	284	-15%
Vermont	367	622	-14%
Nebraska	245	420	-13%
Rhode Island	319	547	-13%
Montana	227	425	-5%
California	349	660	-4%
South Carolina	117	229	0%
Mississippi	60	120	2%
Alaska	400	800	2%
Missouri	150	308	5%
Maine	219	465	8%
Median State	140	191	-30%

Source: Committee on Ways and Means, U.S. House of Representatives. Children in Poverty. U.S. Government Printing Office, Washington, D.C., 1985.

Exhibit 2-3

SSI/SSP Benefit Levels for an Aged Individual
Living Independently
1975 - 1986

State	January 1975	January 1986	Percent change in constant 1986 dollars
Massachusetts	$269	$465	-17%
Nebraska	$213	$391	-12%
Wisconsin	$228	$438	-8%
Minnesota	$189	$371	-6%
New York	$207	$408	-6%
Hawaii	$173	$341	-6%
Oregon	$169	$338	-4%
Nevada	$185	$373	-3%
Idaho	$192	$388	-3%
New Jersey	$182	$368	-3%
Connecticut	$238	$482	-3%
New Hampshire	$170	$350	-1%
Washington	$176	$364	-1%
Colorado	$185	$394	2%
Michigan	$170	$364	2%
Rhode Island	$183	$392	3%
Oklahoma	$183	$396	4%
Maine	$156	$346	6%
Pennsylvania	$166	$369	6%
Vermont	$175	$392	7%
California	$235	$533	9%
Montana	$146	$336	10%
Georgia	$146	$336	10%
Florida	$146	$336	10%
Alabama	$146	$336	10%
Missouri	$146	$336	10%
Mississippi	$146	$336	10%
Kansas	$146	$336	10%
Louisiana	$146	$336	10%
New Mexico	$146	$336	10%
South Carolina	$146	$336	10%
North Carolina	$146	$336	10%
Tennessee	$146	$336	10%
Ohio	$146	$336	10%
Texas	$146	$336	10%
Arkansas	$146	$336	10%
Iowa	$146	$336	10%
Indiana	$146	$336	10%
North Dakota	$146	$336	10%
Virginia	$146	$336	10%
West Virginia	$146	$336	10%
Delaware	$146	$336	10%
Utah	$146	$346	13%
Dist. of Columbia	$146	$351	15%
Alaska	$250	$605	16%
Wyoming	$146	$356	17%
Illinois	NA	NA	NA
Median State	$146	$336	10%

Sources: Social Security Administration, Selected Characteristics of State Supplementation Programs: January 1975 and Characteristics of State Assistance Programs for SSI Recipients: January 1986.

Some States may have been willing to set higher income levels for Medicaid (only) eligibility for AFDC-related families, if Federal regulations had permitted. The problem is that States are often reluctant to update their financial criteria for AFDC because of the added burden to their cash assistance programs, not Medicaid. Whereas the Federal government assumes the entire cash assistance burden for increasing the SSI Federal payment level, States always share in the costs of increasing AFDC levels.[1] It will be interesting to see how States respond to the OBRA 1986 provisions which give them the flexibility to set special Medicaid-only income standards up to the poverty level.

Thus, the most important development in Medicaid eligibility policy over the last deacde has been a substantial shift in the financial criteria used to determine eligibility across the major enrollment groups. Income levels used for the AFDC program (and thus Medicaid) have declined substantially in real - terms while the levels used for the aged and disabled have increased modestly, due to the indexing of Federal SSI standards. In a sense, these changes were passive, rather than active policy decisions. States made AFDC eligibility policy by not raising their AFDC income levels, while increases in SSI levels were largely beyond the States' control. Nevertheless, these financial criteria are pivotal to eligibility determination, and thus must be interpreted as important policy developments in Medicaid, regardless of how the decisions were made.

Moreover, the decline in AFDC income levels were exacerbated by Federal legislative changes which made eligibility for AFDC cash assistance and Medicaid more restrictive for working poor families and older children. However, at the same time, Federal law mandated States to expand their Medicaid coverage of some groups of non-cash children and families, and provided increased flexibility to States to expand their coverage of other such groups of families and children, especially Ribicoff children. In effect, eligibility for Medicaid through the AFDC cash program has been made more restrictive, while eligibility for Medicaid through the non-cash groups has been enhanced.

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[1]Federal participation rates for AFDC cash assistance are generally the same as Medicaid.

What has been the impact of Medicaid eligibility policy changes on Medicaid enrollment? How have changes in Medicaid eligibility policy affected Medicaid's coverage of the poverty population?

The Medicaid eligibility policies discussed in the previous section have had important impacts in determining who actually gets enrolled in Medicaid. Due to the fundamental ties between Medicaid eligibility policy and eligibility for AFDC and SSI, the composition of the Medicaid recipient population underwent a significant transformation between 1975 and 1985. This transformation is not obvious. In fact, the total number of persons receiving medical assistance under Medicaid changed very little over this period. In 1975 the number of Medicaid recipients was 20.3 million, compared to 20.2 million in 1985. However, relative to the size and composition of the overall poverty population, the Medicaid recipient population changed dramatically. These changes, in turn, have had important impacts on the Medicaid program's role in providing medical care for poor persons who lack alternative health care coverage.

AFDC enrollment

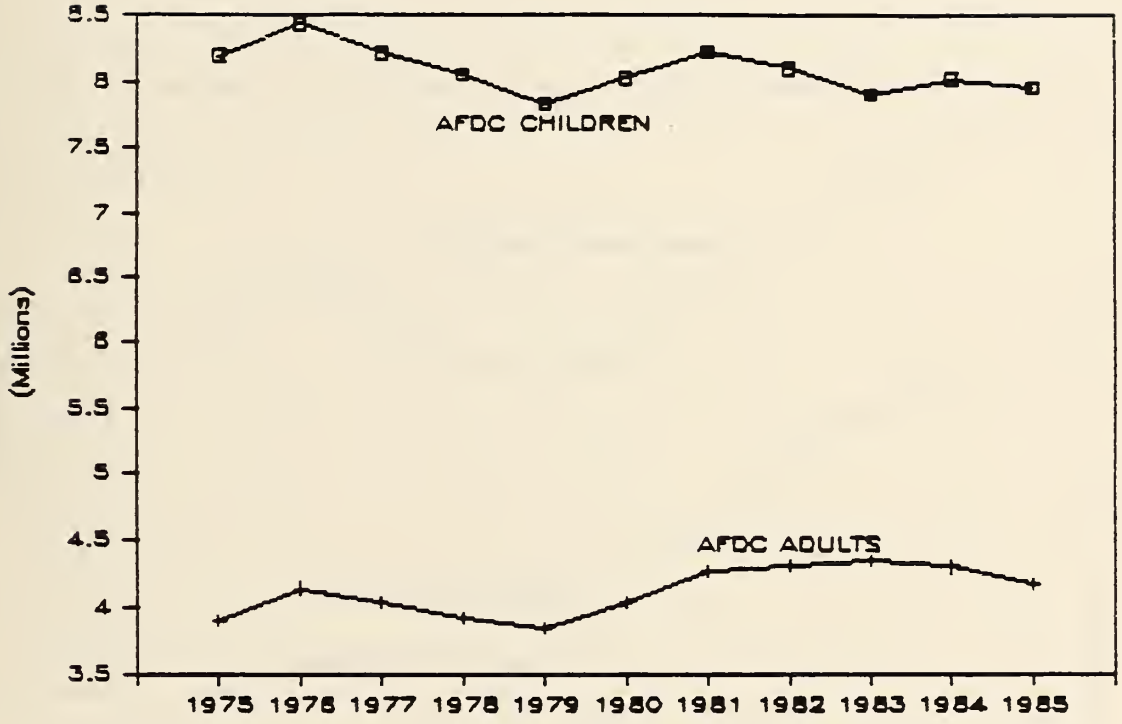
Persons in AFDC-related families comprised 70% of all Medicaid recipients in 1985. Of all AFDC-related families receiving Medicaid, 85% were eligible for Medicaid because they received AFDC payments; 15% did not receive AFDC cash benefits and were eligible for Medicaid only.

Between 1975 and 1985, the number of AFDC cash recipients on Medicaid remained virtually unchanged, at 12.1 million persons (Exhibit 2-4), while the number of non-cash AFDC-related recipients increased. AFDC children receiving cash declined by about 3%, while the number of AFDC adults receiving cash increased by about 7%. The increasing ratio of AFDC adults to children is largely due to a decline in the average size of ADFC family units in recent years.

As shown in Exhibit 2-5, the number of AFDC non-cash recipients has increased significantly, particularly since 1979. Between 1979 and 1985, the number of AFDC adults on Medicaid who were not receiving cash doubled, from

Exhibit 2-4

AFDC Cash Recipients Receiving Medicaid
1975 - 1985

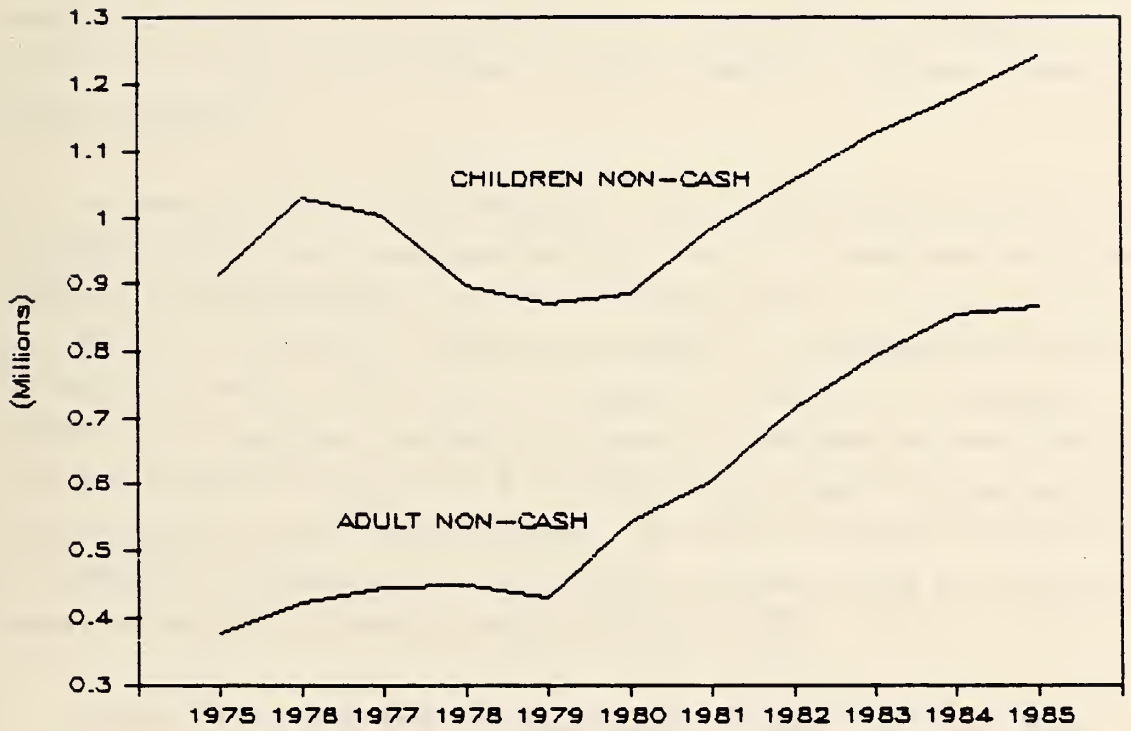


Source: HCFA 2082 data, Bureau of Data Management and Strategy.

Exhibit 2-5

AFDC-Related Non-Cash Recipients Receiving Medicaid

1975-1985



Source: HCFA 2082 data, Bureau of Data Management and Strategy.

432,000 to 865,000. Over the same time period, the number of AFDC-related children receiving Medicaid, but not AFDC, increased 43%, from 871,000 to 1,244,000. Thus, it appears that the Federal legislative changes enacted during the early 1980s have had a definite impact on expanding Medicaid eligibility to AFDC-related families not receiving cash assistance.

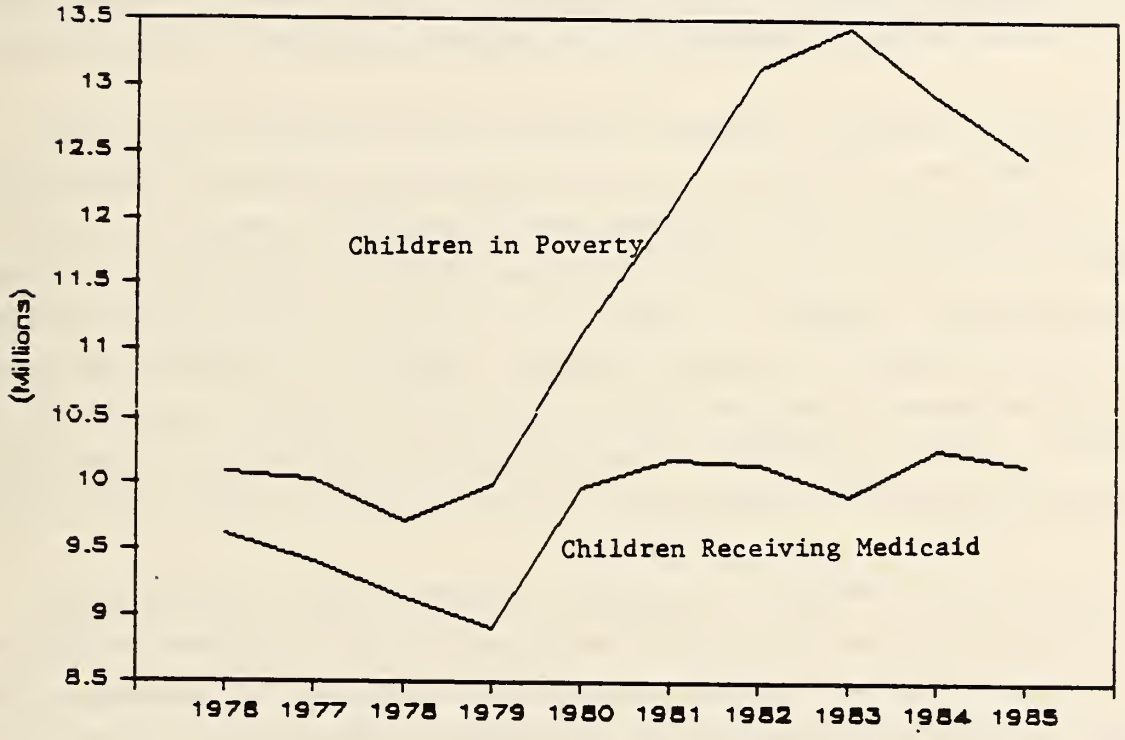
The meaning of this expansion becomes clearer, however, when discussed in the context of overall poverty trends. One measure of the Medicaid program's success in fulfilling its objectives is the degree to which the program responds to national trends in the number of persons living in poverty who have little or no health care coverage. In this context, enrollment trends look rather different.

As shown in Exhibit 2-6, Medicaid's role in providing health care coverage for poor children has eroded considerably. In 1978, there were about 984 children receiving medical assistance through Medicaid for every 1,000 children in poverty. By 1983, that ratio had declined to 737 children receiving Medicaid for every 1,000 children in poverty, a 25% drop in coverage. As Exhibit 2-6 illustrates, although the number of children receiving Medicaid increased moderately between 1978 and 1983, the increase fell far behind the rise in overall poverty among children. By 1985, the ratio had again risen to 813 children on Medicaid per 1,000 children in poverty, due to a decline in the number of children in poverty between 1983 and 1985.

The erosion in Medicaid coverage of poor children is primarily due to two factors. First, the decline in AFDC payment levels has reduced the number of AFDC-related families eligible for Medicaid. As previously discussed, AFDC payment levels declined in real terms by an average of 30% between 1975 and 1985. As a result, a declining percentage of children in poverty were in families which received AFDC payments, and therefore a declining proportion of children in poverty were eligible for Medicaid. While Medicaid eligibility changes did permit expanded coverage of some groups of children above the AFDC income cutoff, the increase in these non-cash child recipients of Medicaid was relatively minor compared to the much larger cutbacks in the AFDC cash assistance program.

Exhibit 2-6

Number of Children in Poverty and Number of Children Receiving Medicaid: 1976-1985



Source: HCFA 2082 data, Bureau of Data Management and Strategy; Social Security Administration, Office of Research and Statistics; and U.S. Bureau of the Census. Number of children receiving Medicaid underestimates Medicaid coverage of children in poverty since it does not include children who were enrolled but received no Medicaid-funded services. Children receiving Medicaid includes all persons reported as "others" (primarily Ribicoff Children) beginning with 1980, although some recipients reported as "others" are not children. Number of children receiving Medicaid prior to 1980 are therefore underreported in this Exhibit. Number of children receiving Medicaid also includes adjustments for number of SSI disabled children receiving Medicaid.

The second reason for Medicaid's eroding coverage of poor children is the fact that an increasing proportion of children in poverty are in two-parent families, a group which has traditionally been eligible for Medicaid only at State option (Ribicoff children). In fact, from 1978 to 1983, the number of poor children increased by 3.6 million, and of these, 2.6 million (79%) were in male-present families (Committee on Ways and Means, 1985). By 1983, children in male-present families comprised almost half (49%) of all poor children. Thus, Medicaid's financial and categorical ties to the AFDC program have both contributed to its declining coverage of poor children in recent years.

Many of the Federal and State Medicaid eligibility changes in recent years have focused on expanding Medicaid's coverage of children in two-parent families. The number of States offering coverage to all Ribicoff children under age 18 has grown from less than 20 States in 1983, to 32 States in 1986 (Children's Defense Fund, 1986). At the same time, Congress has mandated all States not offering full Ribicoff coverage to phase in at least some coverage for this group. Under DEFRA 1984, States were required to extend Medicaid eligibility to all Ribicoff children born after September 30, 1983, up to the age of five. Thus, all States now cover some children in two-parent families.

Unfortunately, these expansions in Medicaid's eligibility provisions have had limited success in reaching low-income children in two-parent families. For the children to be eligible for Medicaid, these two-parent families are still required to meet AFDC (or medically needy) financial criteria. Almost three-fourths of two-parent families living in poverty had annual incomes between $5,000 and $10,000 in 1984. Since the median medically needy income cutoff for a family of four in 1984 was $5,496, the vast majority of poor two-parent families do not meet Medicaid's financial eligibility requirements unless they incur catastrophic health care expenses which cause them to spend-down to Medicaid medically needy levels. Thus, although Medicaid eligibility changes have broadened the base of potentially eligible children, low AFDC and medically needy income cutoffs greatly limit the number of children in two-parent families who qualify financially.

Consequently, it is not surprising that recent analyses estimate that only about 2.2 million of the 6.2 million poor children (35%) in two-parent families

were enrolled in Medicaid in 1985, either under the Ribicoff children or AFDC-U coverage options. Of significance, OBRA (1986) represents the first time that States have been allowed to sever the financial, as well as categorical, ties between the AFDC program and Medicaid. As previously discussed, States may provide Medicaid coverage to pregnant women and children (up to age five, on an incremental basis) in families with incomes up to the Federal poverty level. The OBRA 1986 changes will therefore serve as a major test of whether States are willing to reverse Medicaid's declining coverage of poor women and children by raising their financial eligibility levels for Medicaid only.

SSI Enrollment

Like the AFDC population, the total number of aged and disabled persons receiving Medicaid was virtually the same in 1985 as in 1975. There were 5,911,000 aged and disabled Medicaid recipients in 1975, and 5,927,000 in 1985, an increase of only 0.3%. According to State Medicaid reports (HCFA 2082 data), the number of elderly persons on Medicaid has declined considerably, while the number of disabled Medicaid recipients has steadily increased. However, these State reports are misleading because a growing proportion of disabled Medicaid recipients are, in fact, over age 65. In most cases, persons who originally qualify for SSI cash assistance (and Medicaid) prior to age 65 continue to be classified as disabled after passing their 65th birthday. In 1985, about 22% of all disabled Medicaid recipients receiving SSI cash assistance, some 495,000 persons, were age 65 or over. Thus, while there has been a slight decline in the number of elderly persons receiving Medicaid, the decline is far less than HCFA 2082 data on the aged suggest.

It is true that the number of aged Medicaid recipients receiving SSI cash assistance has declined, even after adjusting for disabled persons over 65, as shown in Exhibit 2-7. This decline reflects enrollment trends in the SSI program itself; the number of elderly persons qualifying for SSI cash payments dropped by over 15% between 1976 and 1985.[1]

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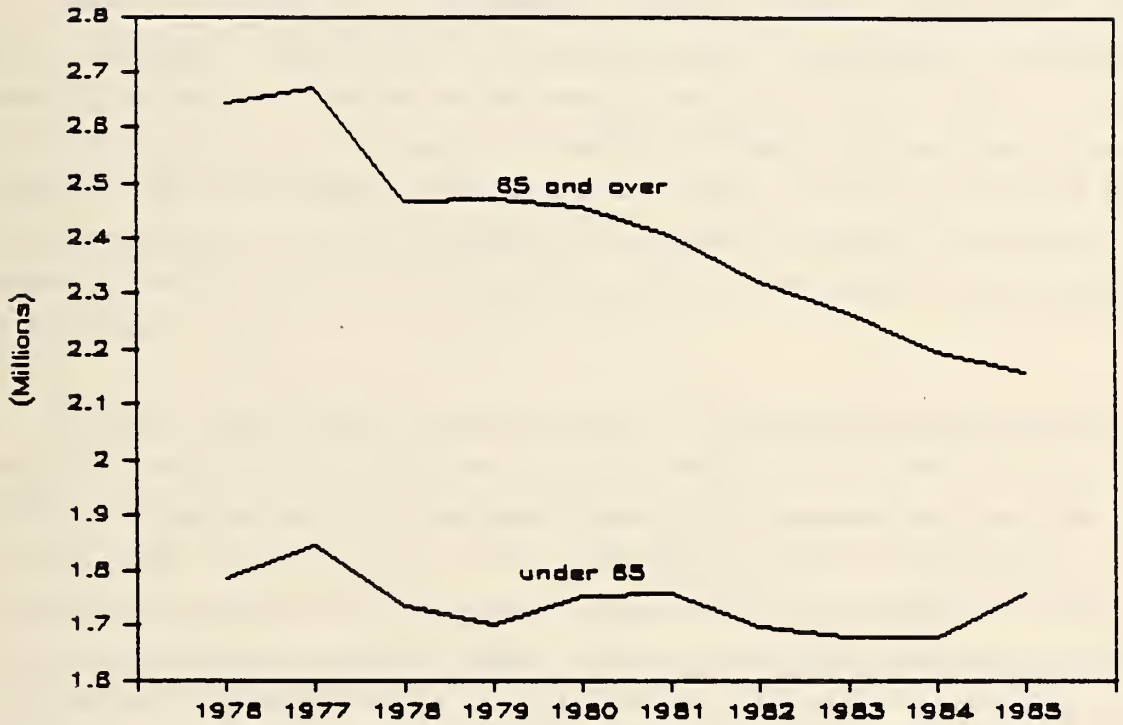
[1]The number of SSI recipients reported by the Social Security Administration and the number of Medicaid recipients who also receive SSI reported by States are not equal because: 1) not all States provide Medicaid coverage for all SSI recipients; 2) some SSI recipients do not use services covered by Medicaid (i.e. they are enrollees, but not recipients); and 3) States report the total number of Medicaid recipients in a fiscal year, while SSA reports SSI recipients as of a specific date.

Exhibit 2-7

SSI Cash Recipients Receiving Medicaid
1976-1985



Source: HCFA 2082 data, Bureau of Data Management and Strategy; and Social Security Administration, Office of Research and Statistics. Data include adjustments for disabled Medicaid cash recipients age 65 and over.

The decline in the number of elderly persons qualifying for SSI assistance is primarily attributable to the overall decline in poverty among the elderly. Between 1976 and 1985, the poverty rate among persons 65 years of age and over dropped from 15.0% to 12.6%. Over the same time period, the percentage of elderly persons qualifying for Federally administered SSI/SSP payments dropped from 10.3% to 7.3%.[1]

However, the decline in the number of elderly persons qualifying for SSI may be reversing. Since 1982, the overall growth in the elderly population has begun to outpace the decline in the poverty rate, particularly among persons over the age of 75. As a result the number of elderly SSI recipients has ceased to decline as shown in Exhibit 2-8. Unless the poverty rate for aged persons continues to fall, the number of aged SSI recipients will again increase, which will in turn increase the size of the aged Medicaid population in the coming years.

As with the AFDC population, the number of aged and disabled Medicaid recipients not receiving SSI cash has grown substantially (Exhibit 2-9). The number of disabled non-cash recipients grew by 30% between 1975 and 1985, and aged non-cash recipients grew by 20%. The growth of the aged non-cash population is primarily attributable to the growth in the number of aged Medicaid recipients in nursing homes. Since nursing home recipients are only eligible for SSI cash payments if their incomes fall below the personal needs allowance (generally $25 per month), only about 14% of the Medicaid nursing home population receive SSI cash. Thus, growth in the Medicaid nursing home population will automatically increase the non-cash population. In fact, 94% of the increase in the aged non-cash population is attributable to growth in the long-term care population. It is not possible to ascertain from available data sources what proportion of these elderly nursing home recipients would have been eligible for SSI cash assistance if they had not been institutionalized.

Reasons for the growth of the disabled non-cash population are more difficult to ascertain. It is not primarily due to increases in the number of

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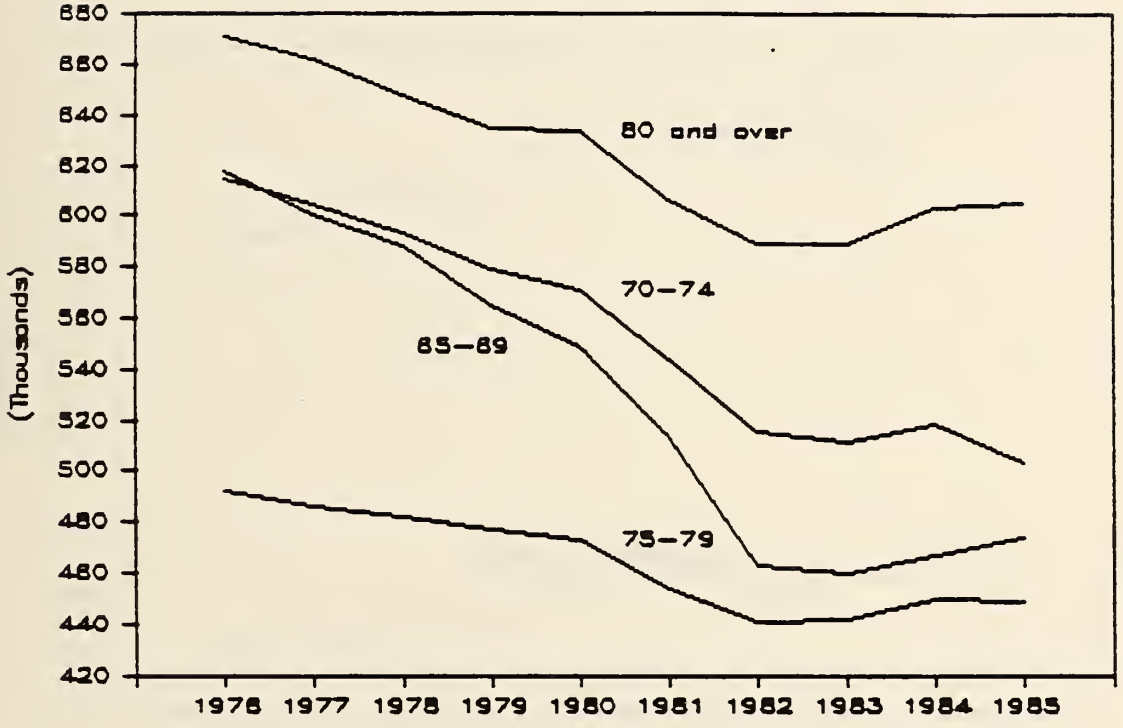
[1]Excludes a small number of elderly persons who receive State-administered supplementation payments only.

Exhibit 2-8

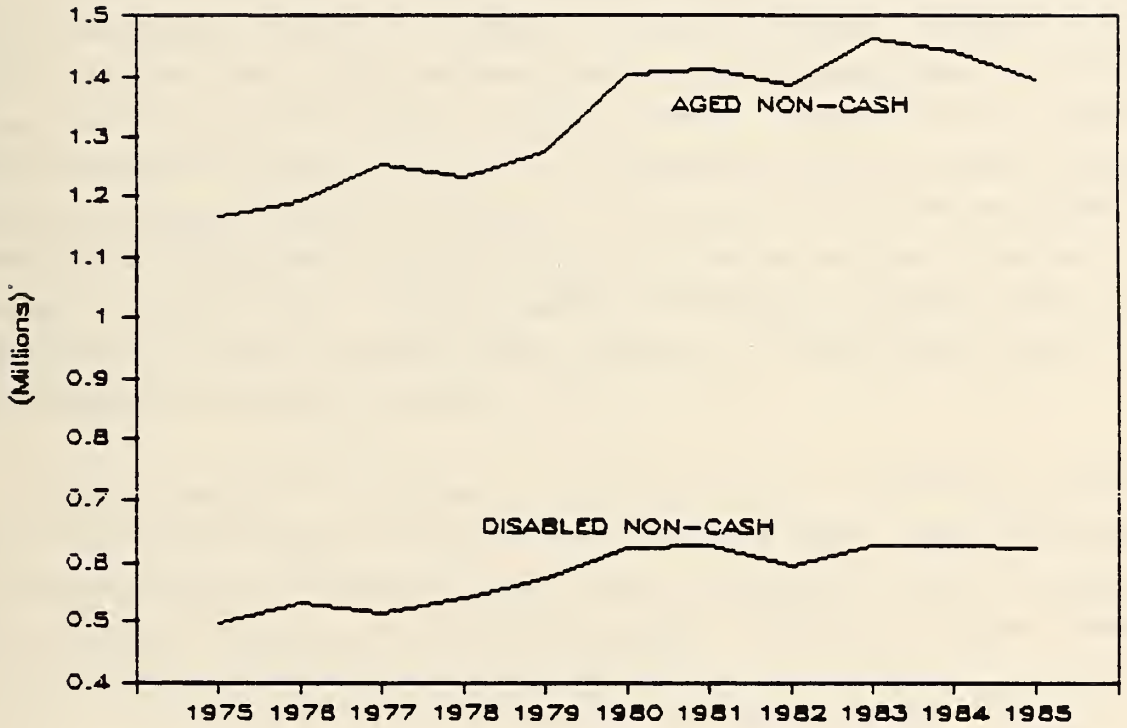
Number of Aged SSI Recipients, by Age Group
1976 - 1985



Source: Social Security Administration, Office of Research and Statistics. Data include adjustments for disabled SSI recipients age 65 years of age and over.

Exhibit 2-9

SSI-Related Recipients Not Receiving Cash
1975 - 1985



Source: HCFA 2082 data, Bureau of Data Management and Strategy. Disabled non-cash recipients over age 65 are reported as disabled.

disabled Medicaid recipients in nursing homes, which accounts for only about 25% of the total increase. It is also not attributable to recent legislation (Section 1619 of the Social Security Disability Amendments of 1980), which has attempted to remove some of the disincentives for disabled SSI recipients to return to work, since there were only about 8,770 persons receiving Medicaid under the Section 1619 program in 1985 (Social Security Administration, 1986).

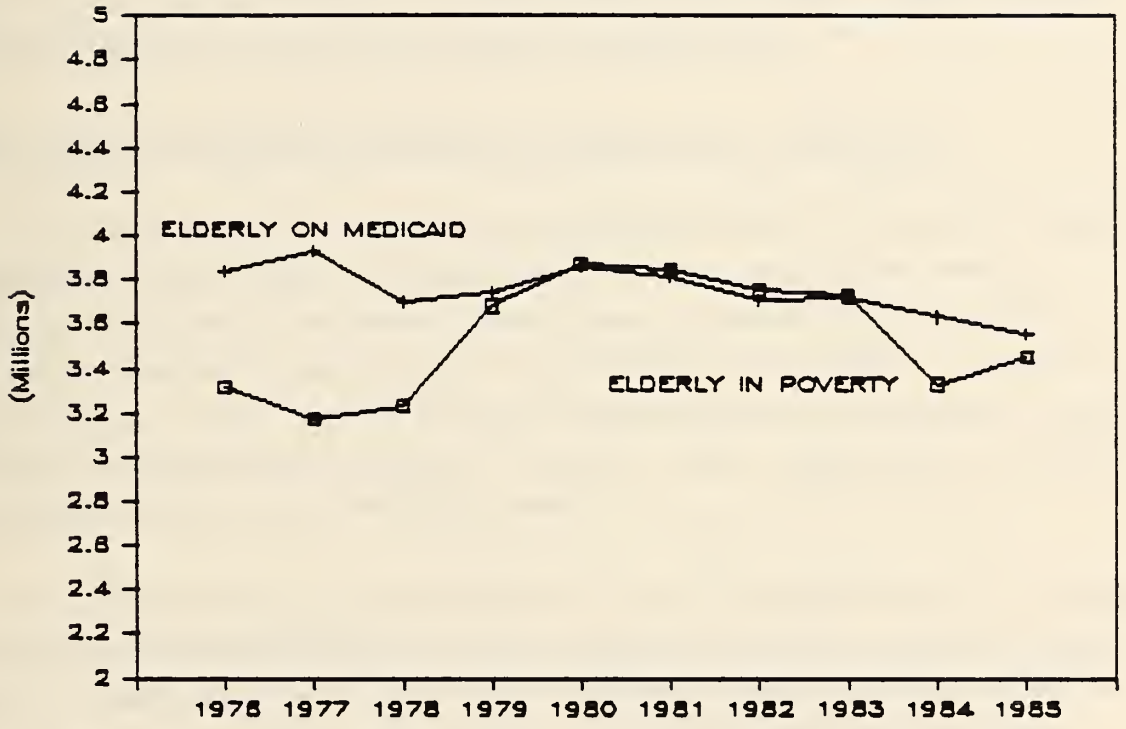
In marked contrast to the erosion in Medicaid coverage for poor children, there has been no erosion in coverage for the elderly poor, as shown in Exhibit 2-10. In 1985, more elderly persons received medical assistance from Medicaid than there were elderly persons living in poverty. Neither the total number of elderly persons living in poverty, nor the number of elderly persons receiving Medicaid changed dramatically between 1975 and 1985. While SSI enrollment among ageds persons has declined slightly, it has not declined relative to the number of elderly poor. Federally mandated increases in SSI/SSP payment levels have clearly not only provided income protection for the elderly poor, but have protected their Medicaid coverage as well.

However, Medicaid's coverage of the elderly poor is confounded by the fact that 38% of aged Medicaid recipients are in nursing homes. Many nursing home recipients qualify for Medicaid under special eligibility rules, and would not be eligible if they were not institutionalized. Indeed, many elderly persons initially qualify for Medicaid after they enter a nursing home.

Among the non-institutionalized elderly, Federal SSI payment levels are still set considerably below the poverty threshold, so there are many elderly persons living in poverty who do not qualify for SSI, and Medicaid. Furthermore, national data on Medicaid's coverage of the elderly poor mask important differences across States. Since States are free to set their State Supplementation Payments (SSP) at whatever level they choose, some elderly persons with incomes above the poverty level can qualify for Medicaid, while elderly persons in other States with incomes substantially below the poverty line do not qualify. For example, in 1984, there were about 206,000 elderly

Exhibit 2-10

Number of Elderly in Poverty and Number of Elderly Receiving Medicaid
1976 - 1985



Sources: HCFA 2082 data, Bureau of Data Management and Strategy; Social Security Administration, Office of Research and Statistics; and U.S. Bureau of the Census. Number of elderly on Medicaid underestimates Medicaid coverage of the elderly poor since it does not include persons who were enrolled in Medicaid but received no Medicaid-funded services. Elderly on Medicaid includes adjustments for the number of disabled Medicaid recipients age 65 and over.

persons living below the poverty line in California.[1] Due to California's generous SSI/SSP payment level, there were about 579,000 elderly Medicaid recipients in California, a ratio of 2.8 to 1. At the other extreme, there were 256,000 elderly persons living below the poverty line in Florida in 1984, but only 136,000 elderly persons received Medicaid, a ratio of .53 to 1.

Since there are no data on the number of disabled persons living below the poverty line, it is difficult to assess Medicaid enrollment trends for the disabled relative to the total number of disabled poor.

What impact have Medicaid eligibility changes had on expenditures?

The Medicaid enrollment trends discussed above have had important impacts on Medicaid expenditures. Although poor families and children make up a growing proportion of the poverty population, the proportion of Medicaid resources directed to poor families and children is declining. As shown in Exhibit 2-11, in 1975, 35% of Medicaid expenditures were for medical services provided to AFDC-related families. Ten years later, AFDC-related recipients accounted for only 24% of Medicaid costs.

This redistribution in expenditures is due to the higher costs of serving the aged and disabled (Exhibit 2-12). Over the 1975-1985 period the average costs per aged and disabled recipient increased at annual compound rates of growth of 4.7% and 4.0%, respectively, in inflation-adjusted dollars.[2] Increases were more moderate between 1980 and 1985 than between 1975 and 1980. For AFDC-related children and adults, average costs per recipient actually declined slightly over this ten-year period. Declines were sharper between 1980 and 1985 than between 1975 and 1980.

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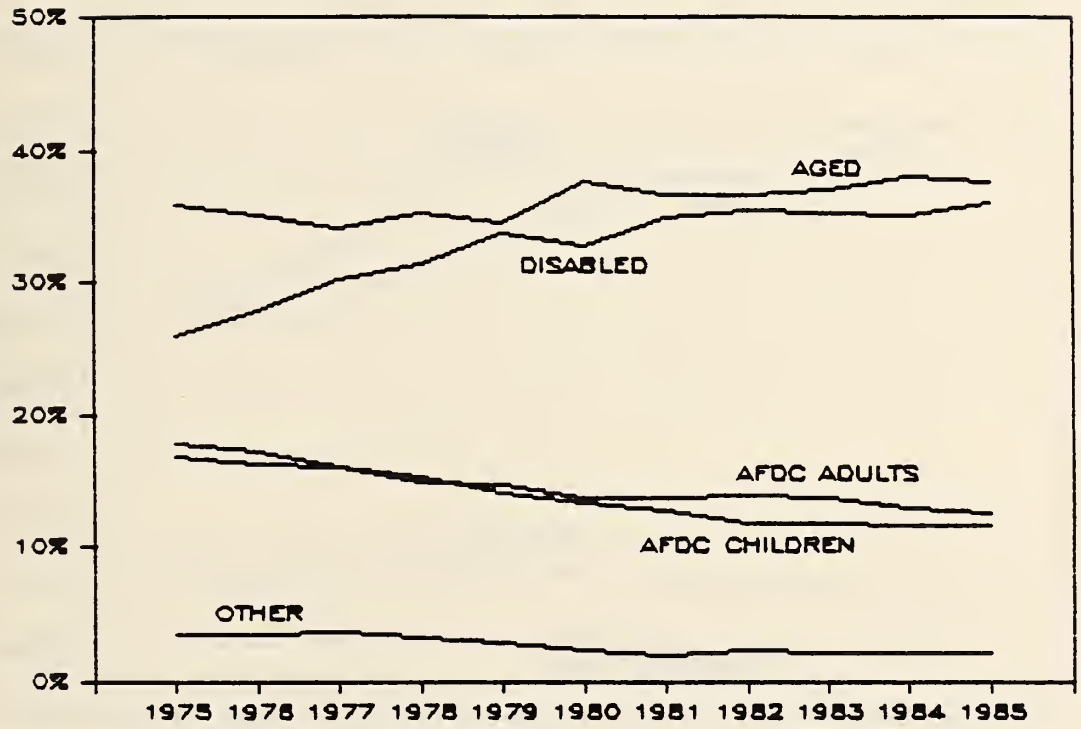
[1]Source: Special tabulations of the Current Population Survey provided by the Urban Institute.

[2]For the analyses presented in this section, disabled recipients age 65 and over are counted as disabled, since national data on Medicaid expenditures for the disabled over 65 are not available.

Exhibit 2-11

Distribution of Medicaid Expenditures, by Eligibility Group
1975 - 1985

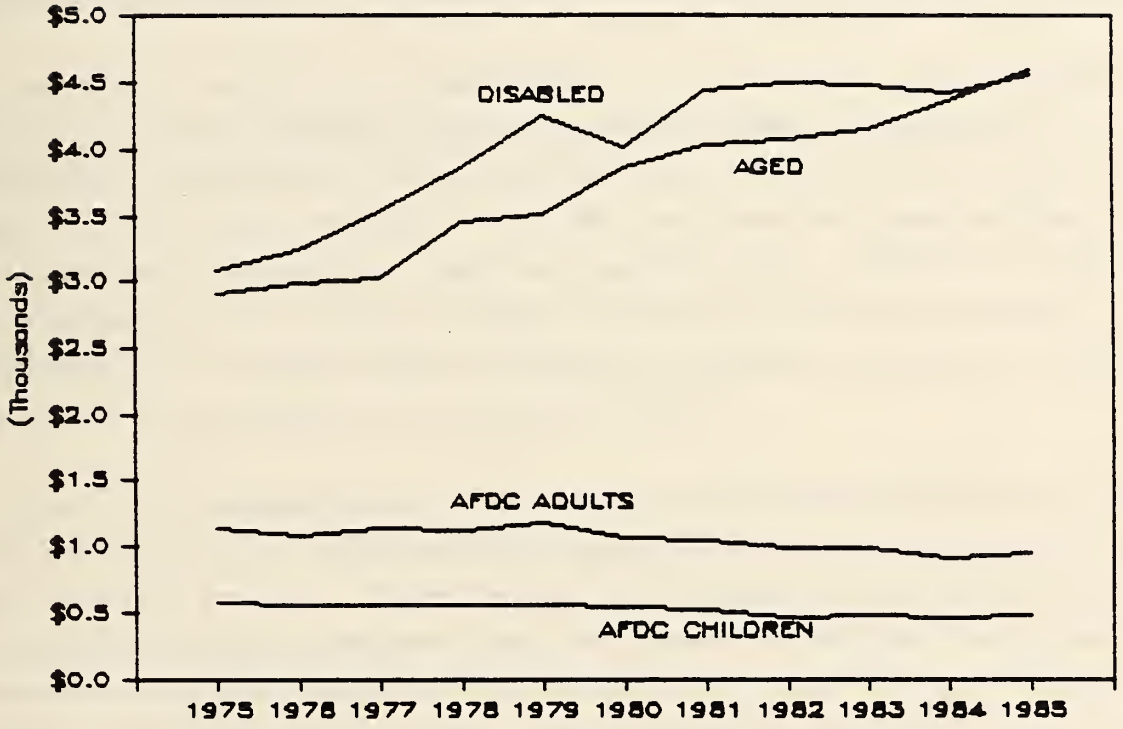


Source: HCFA 2082 data, Bureau of Data Management and Strategy. Expenditures for disabled recipients over age 65 are included in disabled group.

Exhibit 2-12

Average Annual Cost Per Medicaid Recipient, by Eligibility Group
1975 - 1985

(in 1985 dollars)



Source: HCFA 2082 data, Bureau of Data Management and Strategy. Expenditures for disabled recipients age 65 and over are included in disabled group.

Why have average costs for aged and disabled Medicaid recipients outpaced overall price increases in health care? The reasons differ for the two groups. For the aged, part of the increase is attributable to a shift in the mix of services utilized--an increasing proportion of aged Medicaid recipients are long-term care users. While the number of elderly persons receiving Medicaid declined slightly, the number of aged long-term care users increased from 1.0 million to 1.2 million. The proportion of aged Medicaid beneficiaries who were recipients of long-term care services increased from 29.5% to 39.4% over the ten year period. This change in the mix of services used by the aged Medicaid population contributed to increases in the average cost per aged beneficiary.

However, it was not the primary factor. In fact, while an increasing proportion of aged recipients were long-term care users, long-term care expenditures represented a declining proportion of total expenditures for the aged over this period (Exhibit 2-13). The more important trend has been increased costs for services other than long-term care. Between 1975 and 1985, the average cost for non-institutional services (all services excluding long-term care) per aged Medicaid beneficiary increased from $546 to $1,216 in 1985 dollars, an increase in real terms of 123%.[1]

Thus, the increased costs to Medicaid of serving aged beneficiaries is not simply due to the fact that Medicaid provides coverage of nursing home care while Medicare does not. Since Medicaid expenditures for the aged (other than long-term care) mainly represent costs not covered by Medicare (co-insurance, deductibles, extended hospital stays, home health visits which do meet Medicare criteria, prescription drugs, etc.), this increase in non-institutional costs for aged recipients represents a growing burden on State Medicaid programs for costs not covered by Medicare.[2] Further analyses are needed to determine the

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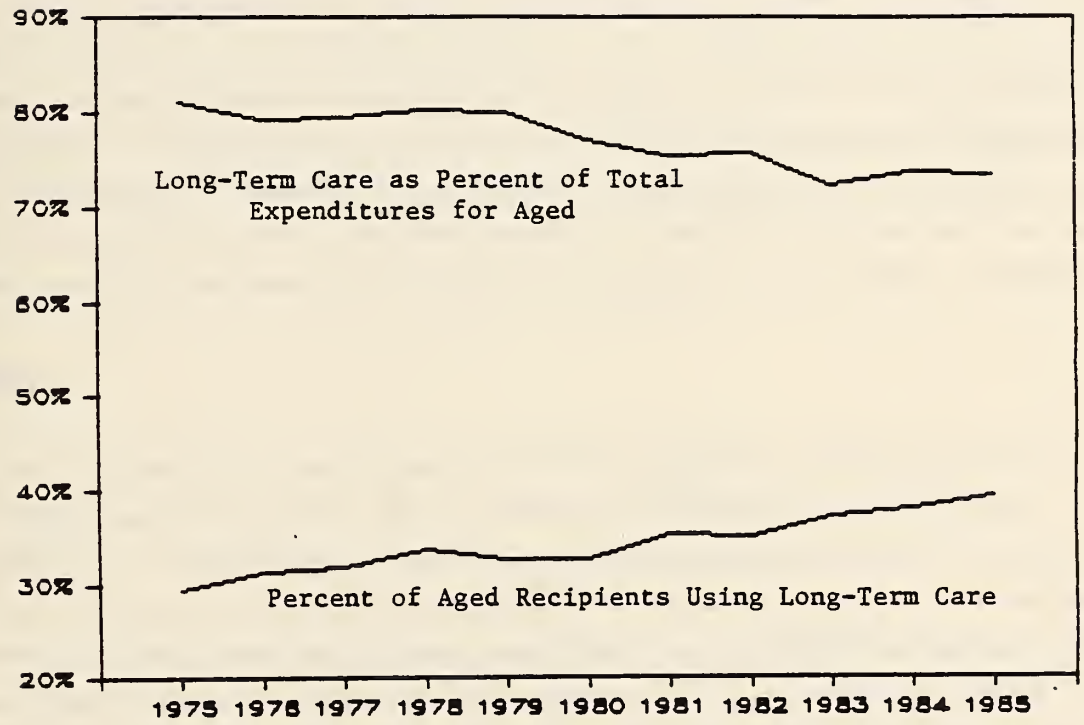
[1]These increases do not include State Medicaid program "buy in" costs for dual enrollees, only increases in payments to providers. Also, since long-term care recipients also incur costs for other Medicaid services (e.g. hospital care, physician services, etc.), it is not possible to ascertain with national Medicaid data to what extent increased costs for non-institutional services are attributable to long-term care recipients and to what extent they are attributable to aged recipients who are not long term care users.

[2]This does not necessarily mean that Medicaid is picking up a larger proportion of the total health care costs for dually enrolled aged beneficiaries, since Medicare costs for the dually enrolled may be rising at an equal, or higher rate.

Exhibit 2-13

Proportion of Total Aged Medicaid Recipients Using Long-Term Care Services and Long-Term Care Expenditures as Proportion of Total Expenditures for the Aged
1975 - 1985



Source: HCFA 2082 data, Bureau of Data Management and Strategy.

factors which underlie cost increases for aged recipients who are not users of long-term care, and to describe more fully the fiscal relationships between Medicaid and Medicare for this dually enrolled population.

For the disabled, it is the increased cost per institutionalized recipient which is driving cost increases. While the percentage of disabled recipients in long-term care facilities did not increase, the average cost per disabled recipient in long-term care almost doubled in inflation-adjusted terms over this period, from $9,000 in 1975 to almost $18,000 in 1985. The primary factor for this increase was the implementation of the ICF-MR program during the late 1970s. ICF-MR recipients account for only about one third of all disabled recipients in long-term care, but for about 70% of long-term care expenditures for the disabled. Between 1975 and 1985, ICF-MR expenditures increased on an inflation-adjusted basis from $908 million to over $4.7 billion and the average annual cost per recipient of ICF-MR care increased from $13,000 to $33,000.

Summary

For the most part, the objective of the legislative changes made to Medicaid eligibility policy since 1980 was to provide States with the flexibility to gain Federal financial participation for persons in poverty who are not on welfare, but who nonetheless lack adequate health care coverage. However, national data on Medicaid enrollment and expenditures indicate that these changes have, to date, had only minor impacts on improving access to Medicaid coverage for persons in poverty. The financial criteria for AFDC and SSI cash assistance remain the primary factors driving Medicaid program enrollment.

The number of Medicaid recipients in 1985 was 20.2 million, compared to 20.3 million in 1975. Over this ten year period there was a dramatic shift in the poverty population, resulting in an increased incidence of poverty among families and children and a decline in poverty among the elderly. Medicaid eligibility policies did not respond to this shift, especially for children and families.

The inflation-adjusted decline in AFDC payment levels between 1975 and 1985 has had a major impact on limiting Medicaid program enrollment for children and families. Because States retain wide discretion over AFDC income levels, and because the majority of Medicaid recipients are eligible through AFDC cash assistance, Federal efforts to expand Medicaid coverage of non-AFDC families and children have only slightly moderated the impact of declining AFDC income levels.

OBRA (1986) for the first time allows States to separate Medicaid eligibility for pregnant women and children from the AFDC or medically needy financial criteria. OBRA 1986 is thus a major test to determine whether States will choose to expand Medicaid enrollment for pregnant women and children with incomes between the AFDC (or medically needy) level and the poverty threshold.

In contrast to AFDC payment levels, raises in Federal SSI payment levels exceeded the rate of inflation between 1975 and 1985. As a result, Medicaid's coverage of the elderly poor has not eroded over time. However, the extend of Medicaid coverage of the elderly poor remains somewhat unclear because almost 40% of all aged Medicaid recipients are in nursing homes. Many poor elderly persons who are not in nursing homes do not have access to Medicaid coverage, particularly in States which do not supplement SSI payments.

Medicaid expenditures are being driven by the costs of serving SSI-related recipients. Average costs per aged and disabled Medicaid recipient have risen in real terms between 4 and 5 percent annually, while costs per AFDC-related recipient have been slightly below the increase in the medical care price index.

Somewhat unexpectedly, the cost of nursing home care is not the major reason why the average cost per aged Medicaid recipient has increased. Rather, costs for aged enrollees receiving Medicaid-covered services other than long-term care have risen at a higher rate. More research on this issue is needed, since it raises questions concerning the cross-program impacts of Medicare and Medicaid, and the role of Medicaid as a catastrophic insurance program for the elderly poor.

In conclusion, although the objective Medicaid was to provide health insurance protection for the poor who lack alternative health care coverage, recent trends in Medicaid eligibility have counteracted this objective. Between 1975 and 1985, poverty rates for the elderly declined, while the incidence of poverty among families and children increased substantially. Medicaid has not responded to this shift in the poverty population. A declining proportion of poor children and families receive medical assistance through Medicaid, while Medicaid's coverage of the elderly poor has been maintained. Due to the higher medical costs of serving aged and disabled recipients, an increasing proportion of Medicaid resources are consumed by aged and disabled recipients. Medicaid's role in providing access to health care services for the vast majority of persons living in poverty, particularly children, has eroded substantially, due to the fundamental ties between Medicaid eligibility and receipt of AFDC cash benefits.

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Chapter 3

RIBICOFF CHILDREN

The Medicaid eligibility trends analysis in Chapter 2 pointed to an erosion over the last decade in Medicaid's coverage of children in poverty. A major factor in this erosion is that Medicaid's close ties to the AFDC program have caused program enrollment to be focused on poor children in single parent families. However, 6.2 million poor children in 1984, or close to half (48%) of the children living in poverty, resided in two-parent families (U.S. Bureau of the Census, 1986), and few of these families would meet the AFDC categorical requirements of dependency.[1]

Medicaid eligibility provisions do allow States to extend coverage to poor children in two-parent families. As an option, States can elect to extend Medicaid to all low-income children whose families do not meet the AFDC dependency requirements, providing they meet certain financial requirements. This is an important option because it enables Medicaid to offer coverage to at least the children in two-parent poor families. This optional coverage group is generally referred to as "Ribicoff children," in recognition of Senator Abraham Ribicoff who sponsored the legislation which first added these children to the Medicaid program.

State Coverage of Ribicoff Children

The number of States offering coverage to all Ribicoff children under age 18 has grown substantially over the last few years, from less than 20 States

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[1]Two-parent families can qualify for AFDC-U coverage if the principal wage-earner is unemployed or underemployed. In 1984, 26 States provided AFDC-U coverage under Medicaid (Rymer, 1986). Two-parent families can also meet the categorical requirements of the regular AFDC program in all the States if one of the parents is ill or incapacitated for at least 30 days. In 1982, about 10% of AFDC families were reported to have both parents in the home (SSA, 1984).

in 1983 to 32 States in 1986 (Hughes et al, 1986 and additional phone survey of selected States). The States now offering full Ribicoff coverage to Ribicoff children under age 18 include:

Alaska[1]	Illinois[1]	Missouri	Oregon
Arkansas	Kansas[1]	Nebraska[1]	Pennsylvania
California	Maine	New Jersey	South Carolina[1]
Connecticut	Maryland	New York	Tennessee[1]
District of Columbia	Massachusetts	North Carolina[1]	Texas[1]
Florida[1]	Michigan	North Dakota	Utah
Georgia[1]	Minnesota	Ohio	Vermont
Iowa	Mississippi[1]	Oklahoma	Wisconsin

At the same time, Congress has mandated that all States not offering full Ribicoff coverage begin a gradual "phase-in" of this group. In 1984, with the DEFRA amendments, States were required to extend Medicaid coverage to Ribicoff children born after September 30, 1983 up to age 5. Thus, all States now have at least some Ribicoff coverage.[2]

Ribicoff Children Recipients

Unfortunately, these expansions in eligibility coverage have not been very effective in reaching low-income children in two-parent families. In 1985, only about 740,000 children were reported to have received Medicaid services under the Ribicoff children group nationwide, using adjusted HCFA 2082 data (Exhibit 3-1). As mentioned earlier, some low-income children in two-parent families were covered as AFDC children for Medicaid due to the incapacity of one parent, or AFDC-U coverage. It is estimated that about 10% of AFDC children were in two-parent families (Social Security Administration, 1984), accounting for another 970,000 Medicaid child recipients in 1985 according to 2082 data.

Not all children enrolled in Medicaid use any services during a year, thus they are not reported as "recipients" in HCFA data. Other research has suggested a service recipiency rate of 85% for AFDC children and 75% for

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[1]States recently adding full Ribicoff coverage.

[2]All States with limited Ribicoff coverage also extend Medicaid to some other subgroups of non-AFDC children, the most common being foster care children not meeting the Title IV-E requirements.

Exhibit 3-1

State Coverage of Ribicoff Children in 1985

Using Adjusted 2082 Data*

	1985 Total Recipients	1985 Ribicoff Recipients**	Coverage of Ribicoff Children	Ribicoff Percent of Total	
United States	20,219,398	741,058		3.67%	
Alabama	316,159	3,935	Partial	1.24%	
Colorado	147,309	NA	Partial	NA	
Delaware	40,564	2,216	Partial	5.46%	
Florida	561,943	5,548	Partial	0.99%	
Georgia	468,887	1,647	Partial	0.35%	
Hawaii	92,238	1,028	Partial	1.11%	
Idaho	38,850	689	Partial	1.77%	
Indianna	283,956	75	Partial	0.03%	
Kansas	141,707	1,952	Partial	1.38%	
Kentucky	408,243	4,395	Partial	1.08%	
Mississippi	416,171	4,416	Partial	1.06%	
Missouri	299,688	1,133	Partial	0.38%	
Montana (A)	47,321	417	Partial	0.88%	
Nevada	28,202	1,472	Partial	5.22%	1.37% Average
New Hampshire	37,698	210	Partial	0.56%	
New Mexico	87,332	38	Partial	0.04%	
North Carolina	343,223	4,572	Partial	1.33%	
Rhode Island	100,750	655	Partial	0.65%	
South Carolina	237,626	268	Partial	0.11%	
South Dakota	33,819	1,159	Partial	3.43%	
Virginia	302,992	5,561	Partial	1.84%	
Washington	326,395	601	Partial	0.18%	
West Virginia	211,407	1,937	Partial	0.92%	
Wyoming	19,546	36	Partial	0.18%	
Alaska	24,017	3,273	Full	13.63%	
Arkansas	197,307	11,790	Full	5.98%	
California	3,380,660	196,000	Full	5.80%	
Connecticut	217,442	13,421	Full	6.17%	
Dist. Columbia	97,805	3,858	Full	3.94%	
Illinois	1,063,367	8,388	Full	0.79%	
Iowa	211,935	15,992	Full	7.55%	
Maine (A)	124,378	2,254	Full	1.81%	
Maryland (A)	328,809	8,000	Full	2.43%	
Massachusetts	522,948	36,623	Full	7.00%	
Michigan	1,133,317	67,182	Full	5.93%	
Minnesota	357,260	34,203	Full	9.57%	
Missouri	355,974	3,658	Full	1.03%	
Nebraska	93,902	5,442	Full	5.80%	5.12% Average
Nevada	36,674	4,329	Full	11.80%	
New Jersey	581,433	14,647	Full	2.52%	
New York	2,242,140	136,763	Full	6.10%	
Ohio (A)	1,045,150	25,146	Full	2.41%	
Oklahoma (A)	269,973	NA	Full	NA	
Oregon (A)	152,502	NA	Full	NA	
Pennsylvania	1,071,029	75,248	Full	7.03%	
Tennessee	362,098	10,129	Full	2.80%	
Texas	761,338	2,640	Full	0.35%	
Utah	72,210	6,121	Full	8.48%	
Vermont (A)	50,385	946	Full	1.88%	
Wisconsin	473,319	10,802	Full	2.28%	

*Adjustments were made for some State 2082 data, based on telephone discussions with State officials about reliability of reported 2082 data related to Ribicoff children. An (A) indicates States for which adjustments were made. NA (not available) entries are used when State had no reliable estimate of Ribicoff recipients.

**Estimates of Ribicoff recipients were made using the number of recipients reported under the "other" categorically needy-no cash and medically needy groups.

Sources: 1. HCFA 2082 data, Bureau of Data Management and Strategy.

2. Dana Hughes, Kay Johnson, Janet Simons and Sara Rosenbaum, Maternal and Child Health Data Book, Children's Defense Fund, Washington, D.C., 1986.

Ribicoff children (Rymer, Adler and Graver, 1987). These assumptions lead to an estimate of about 2.2 million children in two-parent families enrolled in Medicaid during 1984. This estimate suggests that Medicaid provided only limited coverage to poor children in two-parent families, with coverage of about 35% of the 6.2 million children potentially eligible.

Also significant, four States accounted for 67% of the Ribicoff recipients--California, Michigan, New York and Pennsylvania. These same States only accounted for 39% of the overall Medicaid recipient population in 1985.

On average, Ribicoff children were 5.1% of total Medicaid recipients in atates with full Ribicoff coverage in 1984, compared to 1.4% for States with limited Ribicoff coverage (Exhibit 3-1).

Barriers to Medicaid Enrollment for Ribicoff Children

Several factors contribute to Medicaid's limited coverage of Ribicoff children. To start, CPS data for 1985 indicate that about two-thirds of poor two-parent families reported they had some health care coverage during the year (Ellwood, 1987). This would include families already covered by Medicaid (as reported above), State and local medical programs, or Medicare, as well as some families covered by private insurance through an employer. However, this coverage may not have included all children in the family, or it may not have been for the full year. Just over one-third of two-parent poor families reported no health care coverage at all. These families would account for about 2 million children in poverty without any health care coverage.

For families needing health care coverage for some or all of the family members, there are severe financial barriers to enrollment in Medicaid under the Ribicoff provisions. At present, Ribicoff children (or more accurately their families) have to meet the financial requirements of either AFDC or a State's medically needy program. As cited earlier, the financial requirements used by AFDC programs have become very restrictive in recent years as States have failed to keep up with increases in the cost of living. From 1975 to 1985, the income levels used for AFDC eligibility determination declined by

approximately 30% on average, in real terms. In 1985, the median AFDC income eligibility level was $4548 annually for a family of four (Congressional Budget Office, 1985). In 1985, the official poverty level for a family of four was $10,609.

Medicaid law requires that the income levels used for a State's medically needy program can be no higher than 133% of the AFDC level (adjusted for family size). Not all States elect to set their medically needy levels at the maximum amount allowable, especially for larger sized families. In 1984, the median medically needy level for a family of four was $5496 annually (HCFA, 1986). Thus, States have also lagged behind increases in the costs of living in their income levels for the medically needy program.

Close to three-fourths (73%) of two-parent poor families in 1984 are estimated to have had income between $5000 to $10,000 annually (U.S. Bureau of the Census, 1986). Since the median AFDC income level (for a family of four) was $4548, and the median medically needy income level in 1984 was $5496, most poor two-parent families would not meet the financial eligibility requirements of Medicaid. In States with medically needy coverage, a family could spend-down its "excess" income on medical expenses in order for the children in the family to become eligible for Medicaid through the Ribicoff provisions. But, often the size of the spend-down requirement is prohibitive unless medical expenses are substantial. For example, if the medically needy level was $5500 annually, a family with income of $8000 would have to have annual medical expenses of at least $2500 in order for the children to become Medicaid eligible. The resource restrictions of the AFDC and medically needy programs may also be a factor in preventing low-income families from attaining Medicaid eligibility.

Finally, there are reported to be other non-financial barriers to Medicaid eligibility. Many low-income two-parent families may not be aware that Medicaid is an option for their children and thus may never apply for coverage. Even for those who attempt Medicaid eligibility, spending-down excess income on medical expenses to qualify under the medically needy provisions is repeatedly cited as a confusing and difficult process to both applicants and providers.

Characteristics of Ribicoff Children in Using Medicaid

Data are available from HCFA's Tape-to-Tape research project which provide a detailed profile of Ribicoff children in California, New York and Michigan (Rymer, Adler and Graver, 1987). These States accounted for 49% of Ribicoff recipients in 1985. The Tape-to-Tape data suggest that Ribicoff children are very different from AFDC children on Medicaid (Exhibits 3-2 and 3-3):

- Ribicoff children were much older than AFDC children. From 12% to 17% of the AFDC child population was over age 14, compared to 36% to 65% of Ribicoff children reported in this age category among the study States. Some of the age distribution difference occurred because Ribicoff coverage was extended to 19 and 20 year olds for the study States, whereas AFDC coverage for children only extended through age 18. However, this would not account for all of the difference.

- Ribicoff children experienced greater turnover during a year. AFDC children on average were enrolled for about 9 months out of a calendar year, compared to 6 to 8 months for Ribicoff children.

- Ribicoff children were less likely to be recipients of Medicaid services during the year than AFDC children (i.e. have used at least one Medicaid service).

- Ribicoff children were more likely to be hospitalized during the year than AFDC children. Generally, the hospital utilization rate for Ribicoff children was 11% to 12%, compared to 4% to 9% for AFDC children. Ribicoff children also stayed longer in the hospital.

- Ribicoff children were less likely to use physician/ambulatory care services during the year than AFDC children. However, if they used physician/ambulatory care services, they reported more visits on average than AFDC child users.

- Not surprisingly, Ribicoff children also cost more. The average annual expenditure for a Ribicoff child enrolled the full year ranged from $971 in New York to $1078 in Michigan to $1239 in California, compared to annual costs of $367 (Michigan) and $419 (California) to $556 (New York) for a full year AFDC child.

Thus, Tape-to-Tape data suggest that Ribicoff children are sicker and more expensive than children enrolled in Medicaid through the AFDC provisions. Also significant, most Ribicoff expenditures are for infants (<1 year) and older teenagers (15-20 years). In California, 77% of Ribicoff costs were attributable to these age groups, compared to 72% for Michigan, and 62% for New York (Exhibit 3-4).

Exhibit 3-2

Distribution of AFDC and Ribicoff Children by Age
California, Michigan (1983) and New York (1982)

Age Group	AFDC Children			Ribicoff Children		
	CA	MI	NY	CA	MI	NY
<1 Year	12%	10%	11%	18%	7%	11%
1-4 Years	29%	27%	24%	22%	10%	19%
5-9 Years	26%	27%	25%	14%	8%	17%
10-14 Years	21%	24%	23%	10%	9%	17%
15-18 Years	12%	12%	17%	15%	26%	21%
19-20 Years	--	--	--	21%	39%	16%
Total	100%	99%	100%	100%	99%	101%

Source: Tape-to-Tape Uniform Files as reported in Medicaid Children (Rymer, Adler and Graver, 1987).

Exhibit 3-3

Selected Medicaid Data for AFDC and Ribicoff Children*

California, Michigan (1983) and New York (1982)

	AFDC Children			Ribicoff Children		
	CA	MI	NY	CA	MI	NY
Mean Length of Enrollment (Months)	8.8	9.4	9.0	5.8	8.0	7.4
Percent Recipients	81%	85%	87%	73%	83%	70%
Percent Inpatient Hospital Users	4%	6%	9%	11%	12%	11%
-Hospital Days Per User	8	7	9	12	9	11
Percent Physician/Ambulatory Care Users	64%	76%	81%	58%	73%	62%
-Visits Per User	7	6	8	10	7	10
Annual Expenditure Per Enrollee	$419	$367	$556	$1239	$1078	$971

*Calculated using person years

Source: Tape-to-Tape Uniform Files as reported in Medicaid Children (Rymer, Adler and Graver, 1987).

Exhibit 3-4

Distribution of Expenditures for Ribicoff Children by Age

Age Group	California	Michigan	New York
<1 Year	33%	12%	20%
1-4 Years	11%	6%	15%
5-9 Years	6%	7%	10%
10-14 Years	5%	15%	12%
15-18 Years	16%	30%	21%
19-20 Years	28%	30%	21%
Total	99%	100%	99%

Source: Tape-to-Tape Uniform Files as reported in Medicaid Children (Rymer, Adler and Graver, 1987).

Diagnosis data were only available in one Tape-to-Tape State--Michigan.[1] The Michigan data indicate that almost half of inpatient hospital expenditures for Ribicoff children were related to childbirth and infants (especially high cost infants). More specifically, some 27% of Ribicoff child hospital expenditures went to pregnancy and childbirth-related diagnoses, with another 13% for conditions originating in the perinatal period (for example, short gestation, low birthweight, and extreme immaturity). Congenital anomalies accounted for 3% of hospital expenditures, plus another 6% for newborns (Exhibit 3-5).

These same categories accounted for 30% of AFDC child hospital expenditures in Michigan, with the major difference attributable to pregnancy and childbirth charges. Only 4% of AFDC child charges were in this category, compared to 27% for Ribicoff children. Michigan officials were asked why teenage mothers are being enrolled as Ribicoff children, rather than AFDC adults since pregnant women no longer have to meet the AFDC categorical requirements. The response was that it is easier to determine eligibility under the Ribicoff provisions, since no verification of pregnancy is required.

Michigan did have a much higher proportion of older teenagers in its Ribicoff program than the other two States in the Tape-to-Tape data set. Thus, these diagnosis data may not be representative. Nevertheless, they suggest that Ribicoff coverage is focused on maternal and high cost infant services, not routine child care for children of all ages.

Summary

Even with the expansions in Ribicoff coverage over the last few years, many low-income children in two-parent families have not become eligible for Medicaid. Coverage has generally occurred only when there has been a family member with unusually high medical expenses, given the financial eligibility levels used by the AFDC and medically needy programs. In particular, high cost infants and older teenagers account for a high proportion of Ribicoff enrollment and expenditures. Thus, in a sense, the coverage of Ribicoff

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[1]These data reported the primary diagnosis for each hospital stay according to ICD-9-CM categories.

Exhibit 3-5

Percent Distribution of Inpatient Hospital Discharges and Expenditures by ICD-9-CM Diagnostic Category for AFDC and Ribicoff Children Michigan, 1983

Diagnostic Category	AFDC Children: % of Total Discharges	AFDC Children: % of Total Expenditures	Ribicoff Children: % of Total Discharges	Ribicoff Children: % of Total Expenditures
Infectious and Parasitic Diseases	5%	4%	3%	2%
Neoplasms	<1%	1%	1%	2%
Endocrine, Nutritional, and Metsbolic Diseases and Immunity Disorders	2%	2%	2%	2%
Diseases of the Blood and Blood Forming Organs	2%	1%	<1%	1%
Mental Disorders	<1%	<1%	2%	1%
Diseasea of the Nervoua System & Sense Organs	5%	4%	3%	3%
Diseasea of the Circulatory System	1%	1%	1%	1%
Diseases of the Reapiratory System	33%	23%	11%	8%
Diseases of the Digeative System	12%	9%	8%	7%
Diseasea of the Genitourinary System	3%	3%	6%	5%
Complications of Pregnancy, Childbirth and the Puerperium	5%	4%	36%	27%
Diseases of the Skin and Subcutaneoua Tissue	2%	1%	1%	1%
Diseasea of the Musculoakeletal System and Connective Tissue	1%	2%	1%	2%
Congenital Anomalies	3%	6%	1%	3%
Certain Conditions Originating in the Perinatal Period	4%	12%	3%	13%
Symptoms, Signs & lll-Defined Conditions	7%	6%	5%	3%
Injury and Poisoning	11%	10%	10%	12%
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V Codes associated with single liveborn infant in parentheses)	4% (3%)	9% (8%)	5% (4%)	7% (6%)
Supplementary Classification of External Causes of Injury and Poisoning	<1%	<1%	<1%	<1%
Total	100%	99%	100%	100%

Source: Tape-to-Tape Uniform Files as reported in Medicaid Children (Rymer, Adler and Graver, 1987).

children by a State has been used to extend Medicaid to low-income children with unusually high medical expenses, not low-income children with routine health care needs.

The recent OBRA 1986 amendments will provide States with an option to substantially reduce Medicaid's financial eligibility barriers for at least some groups of children. OBRA 1986 gives States the option to extend Medicaid to pregnant women (including teenagers and infants) and children through age 5 (on an incremental basis) in families with incomes up to the Federal poverty level. Since infants and pregnant teenagers appear to account for a large proportion of Ribicoff expenditures, the OBRA 1986 amendments will assist States in better reaching these groups with obvious health care needs. Of equal importance, however, is that OBRA 1986 will enable States to extend Medicaid coverage for routine child health care needs to younger children in low-income two-parent families. Since a large spend-down will no longer be required of a family if a State uses the Federal poverty level to determine eligibility, younger low-income children without unusually high medical expenses will be able to secure coverage.

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Chapter 4

DISABLED CHILDREN

Disabled children are another group of Medicaid enrollees about which we know very little. In fact, disabled children were not even eligible for Medicaid (in their own right) until the implementation of the SSI program in 1974. Prior to SSI, disabled children generally had qualified for cash assistance and Medicaid only if their families were eligible through the AFDC provisions. With SSI, children became eligible if they were substantially disabled and if they satisfied certain modified income and resource requirements. Adult disability determinations are based largely on whether a person is capable of work. For children, disability assessment generally focuses on the impact of a child's handicap on normal daily activities.

HCFA does not collect any data on disabled children in the Medicaid program, so it is not possible to report the number of disabled children receiving Medicaid nationwide, or their level of expenditures. Not all States extend Medicaid coverage to disabled children. Among the fourteen States which use more restrictive Medicaid eligibility provisions for the aged and disabled, a few (including Connecticut, Minnesota, Missouri, New Hampshire, and North Carolina) have chosen not to extend Medicaid to disabled children. In these States, disabled children generally can only qualify for Medicaid through AFDC or Ribicoff children eligibility requirements.

Characteristics of Disabled Children

An SSA survey in 1979 produced the following profile of (non-institutionalized) disabled SSI children:

> Approximately 85% of SSI disabled children lived at home with their families, while about 15% lived in foster care or other protective settings. The average age was around 12 years. They were more likely to be male (58%). They had a greater proportion of minorities than the general or low-income population. The average household size was 5 persons (including the child). In just over half the households (57%), the mother was the only parent present.

The majority of children (53%) were reported by their caretakers to be multiply handicapped. The data on the main disabling conditions showed mental retardation to be the most frequently occurring main disability (27% of the children). Fifteen percent indicated that "other diseases of the nervous system" were the main handicap. This group covers several conditions including epilepsy, brain disease, meningitis, muscular dystrophy and multiple sclerosis. Another 15% reported "other mental conditions," such as psychosis, schizophrenia, neurosis, personality disorders, alcoholism, drug problems, speech defects, hearing defects and hyperactivity. Congenital anomalies, such as spina bifida, Down's syndrome and hydrocephalus, were reported as the main disabling condition for 11% of the children (Rymer, Reither, Goldman and Van De Vanter, 1980).

SSI Disabled Children: 1974-1984

In 1974, the first year of implementation, the number of disabled children (under age 22) receiving SSI cash assistance was 101,647. Over the next ten years, enrollment more than tripled, reaching 346,931 children by 1984. Although growth was dramatic in the early years, it had stabilized by 1979 (Exhibit 4-1). Data from recent years suggest an annual growth rate around 5%, a rate slightly greater than that of the adult disabled population. Thus, children are expected to be a slowly increasing proportion of the SSI disabled population.

Children were about 14% of disabled (and blind) SSI enrollment in 1984. However, the proportion of children in the disabled population varied considerably among States from a low of 9% (California) to a high of 24% (South Dakota). Generally, children were a higher proportion of SSI enrollment in States which offer no supplementation to the basic SSI Federal assistance grant, or very low supplementation.

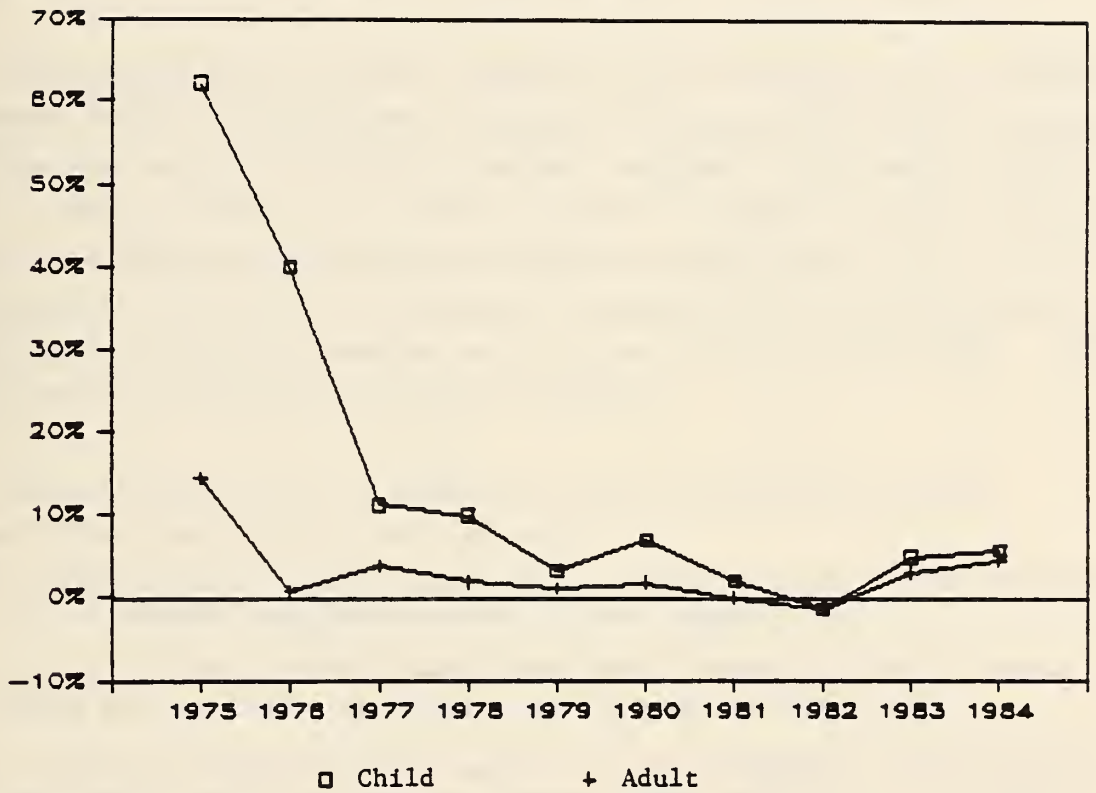
Characteristics of Disabled Children in Using Medicaid

Data are available from HCFA's Tape-to-Tape research project which provide a detailed profile of disabled children in four States--California, Georgia, Michigan and New York (Rymer, Adler and Graver, 1987).[1] These States accounted for 26% of SSI disabled children nationwide in 1984. Among the four

[1]The California and Michigan Tape-to-Tape data are for 1983, while the Georgia and New York data are for 1982.

Exhibit 4-1

Annual Growth Rate of Disabled SSI Recipients: 1975-1984



States, children were from 7%-12% of the total Medicaid disabled population (including non-cash disabled children), and 1%-2% of total Medicaid enrollees. Children were a smaller percent of the total Medicaid disabled population than of the total SSI population because children were less likely to be enrolled as non-cash Medicaid enrollees than disabled adults. Also, the Tape-to-Tape data define children as disabled enrollees under 21 years of age, compared to the age cutoff of 22 years used for the SSI counts.

The distribution of disabled children by cash assistance status varied somewhat among the study States, although cash assistance children accounted for the vast majority of disabled Medicaid children in each State (Exhibit 4-2). They were almost the entire enrollment in Georgia because the State did not have a medically needy program during the study period. Study results suggest that a medically needy program increased disabled child enrollment in Medicaid by 1% to 3% in Michigan and California, but 13% in New York. There is no obvious explanation for this difference.

The following profile of disabled children was derived from the Tape-to-Tape data (Exhibits 4-3 and 4-4):

- Most disabled children were older. Among the study States, from 46% to 57% of disabled children were age 15 to 20 years.

- Most disabled children were recipients of Medicaid services during the study year, with the recipiency rate varying from 82% to 89%.

- The hospitalization rate varied from 13% (Michigan) to 20% (Georgia). The average number of days per hospital user ranged from 13 (Georgia) to 30 (New York).

- About 70% of disabled children had at least one physician/ambulatory visit for the year in each of the study States. The number of visits per user varied from 9 (Michigan) to 18 (New York) among the States.

- The proportion of disabled children using long-term care services was about the same for California, Michigan and New York, ranging from 9% to 11%. Georgia reported only 6% of disabled children using long-term care services.

- Annual Medicaid expenditures per disabled child enrolled for the full year ranged from $3135 in Georgia to $5558 in New York. The most striking result is that although only a small portion of disabled children used institutional services in each State, long-term care services accounted for at least half of Medicaid expenditures for disabled children.

Exhibit 4-2

Distribution of Disabled Children by Cash Assistance Status
Georgia and New York (1982), California and Michigan (1983)

	Disabled Children			
	CA	GA	MI	NY
Receiving Cash Assistance	96%	99%	98%	86%
Not Receiving Cash Assistance*	4%	1%	2%	14%
Total	100%	100%	100%	100%

*Includes both categorically needy, not receiving cash assistance and medically needy.

Source: Tape-to-Tape Uniform Files as reported in Medicaid Children (Rymer, Adler and Graver, 1987).

Exhibit 4-3

Distribution of Disabled Children by Age
Georgia and New York (1982), California and Michigan (1983)

	Disabled Children			
Age Group	CA	GA	MI	NY
<1 Year	1%	2%	1%	4%
1-4 Years	9%	11%	8%	9%
5-9 Years	17%	18%	15%	16%
10-14 Years	22%	23%	19%	24%
15-18 Years	26%	27%	28%	28%
19-20 Years	25%	19%	29%	20%
Total	100%	100%	100%	101%

Source: Tape-to-Tape Uniform Files as reported in Medicaid Children (Rymer, Adler and Graver, 1987).

Exhibit 4-4

Selected Medicaid Data for Disabled Children*
Georgia and New York (1982), California and Michigan (1983)

	Disabled Children			
	CA	GA	MI	NY
Percent Recipients	89%	86%	87%	82%
Percent Inpatient Hospital Users	14%	20%	13%	16%
-Hospital Days Per User	16	13	14	30
Percent Physician/Ambulatory Care Users	73%	71%	77%	71%
-Visits Per User	14	10	9	18
Percent Long-Term Care Users	10%	6%	11%	9%
-Long-Term Care Days Per User	302	336	300	245
Annual Expenditure Per Enrollee				
-Hospital	$1,431	$1,077	$ 830	$1,672
-Long-Term Care	$2,597	$1,467	$3,035	$2,988
-Other	$1,164	$ 691	$ 601	$ 897
Total	$5,192	$3,135	$4,466	$5,558

*Calculated using person years

Source: Tape-to-Tape Uniform Files as reported in Medicaid Children (Rymer, Adler and Graver, 1987).

Another way of analyzing expenditure patterns for disabled children is to subdivide the population by institutional status and cash assistance status, as shown in Exhibit 4-5. These data show that institutionalized children who used long-term care services during the year were much more expensive on a per enrollee basis than other disabled children, with costs ranging from $25,053 per child in Georgia to $36,388 in New York. Most of the expense for institutionalized disabled children in each State can be attributed to ICF-MR facilities.

The data also show for children who were not institutionalized that non-cash disabled children were considerably more expensive on a per enrollee basis than cash disabled children. In California, expenditures for non-cash children (non-institutionalized) were 700% greater than expenditures for cash children, compared to 500% for New York and 300% for Michigan. Inpatient hospital costs accounted for most of the greater expenditures for non-cash children.

In all the States but Michigan, the annual Medicaid cost per disabled child enrollee was greater than the cost for adult disabled enrollees, as shown in Exhibit 4-6. In California, the per enrollee expenditure for disabled children was 72% greater than the expenditure per disabled adult. In Georgia, it was 38% more, and 28% more in New York. Only in Michigan were the costs for disabled children about the same as the adult disabled. Much of the difference could be attributed to the greater expense for long-term care for disabled children. Although about 10% of disabled children and 10% of disabled adults were institutionalized during the year, disabled children were much more likely to be in the more expensive ICF-MR facilities. This makes the long-term care expenditure per enrollee for disabled children higher than the per enrollee expenditure for the adult disabled. Another factor is that a sizeable portion of the adult disabled group (about one-third) are also eligible for Medicare, while disabled children are not generally eligible for Medicare. As a result, Medicaid is covering the entire health care costs for disabled children, while it only covers part of the costs for the adult disabled.

Exhibit 4-5

Annual Expenditures Per Disabled Child Enrollee
by Institutional and Cash Assistance Status*
Georgia and New York (1982), California and Michigan (1983)

	Disabled Children			
	CA	GA	MI	NY
Non-Institutionalized				
-Receiving Cash Assistance	$ 2,615	$ 1,694	$ 1,347	$ 1,956
-Not Receiving Cash Assistance	$17,675	--	$ 4,120	$ 9,715
Institutionalized	$27,882	$25,053	$29,967	$36,388

*Calculated using person years

Source: Tape-to-Tape Uniform Files as reported in Medicaid Children (Rymer, Adler and Graver, 1987).

Exhibit 4-6

Annual Expenditures Per Disabled Child and Adult Enrollees*
Georgia and New York (1982), California and Michigan (1983)

	CA	GA	MI	NY
Disabled Child Enrollee	$5,192	$3,135	$4,466	$5,558
Disabled Adult Enrollee	$3,015	$2,273	$4,512	$4,336

*Calculated using person years

Source: Tape-to-Tape Uniform Files as reported in Medicaid Children (Rymer Adler and Graver, 1987).

Summary

Tape-to-Tape data indicate that although disabled children were only 1% to 2% of total Medicaid enrollment among the study States, they accounted for 3% to 6% of total expenditures. About half of the expenditures for disabled children were attributable to long-term care expenses, although only about 10% of the disabled child population was institutionalized during the study year. Disabled children had a greater annual Medicaid cost per enrollee than the adult disabled population. This occurred because disabled children are not generally covered by Medicare, and disabled children tend to use more expensive long-term care, especially ICF-MR care. Thus, disabled children are an enrollment group States should carefully follow. They are a slowly increasing portion of the disabled population. They are also a group whose cumulative impact over time on Medicaid expenditures could be significant. Unlike other Medicaid enrollees, disabled children can generally be expected to remain on Medicaid for many years, perhaps their entire lives.

Chapter 4 References

1. Rymer, M., Adler, G., and Graver, L. Medicaid Children (Draft Report). SysteMetrics/McGraw-Hill, February, 1987.

2. Rymer, M., Reither, M., Goldman, R., and Van De Vanter, M. Survey of Blind and Disabled Children Receiving SSI Benefits. Urban Systems Research and Engineering, Inc., 1980.

Chapter 5

ICF-MR RECIPIENTS

Developmentally disabled persons receiving care in Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) are one of the highest-cost populations in Medicaid. In FY 1985, the 143,846 individuals receiving care in ICFs-MR represented only 0.7% of all Medicaid recipients (note 1). Yet the $4.7 billion spent for ICF-MR care accounted for 12.7% of all Medicaid expenditures for that year. And while ICF-MR recipients represent only 5% of all disabled Medicaid recipients, they account for about 35% of all Medicaid expenditures for the disabled. In 1985, the average annual cost per recipient of ICF-MR care was $32,960.

Despite the large amount of money which is spent for ICF-MR care each year in Medicaid, there is little information available about how these resources are spent, and what programmatic outcomes are being achieved. For one, the ICF-MR program is relatively new to Medicaid. The ICF-MR benefit was added to Medicaid under the Social Security Amendments of 1971 (P.L. 92-223) within a larger provision which shifted Federal support of Intermediate Care Facilities for the aged and disabled into Medicaid. Prior to 1971, institutional care for developmentally disabled persons was primarily funded with State general funds. With the enactment of the ICF-MR program, States were offered the opportunity to gain between 50 and 77% Federal participation for the cost of their State institutions, if these institutions were brought into compliance with Federally-established facility and treatment standards. Understandably, under this type of financial incentive, States moved rapidly to bring their institutions into compliance with ICF-MR standards.

This chapter provides an overview of ICF-MR program trends between 1975 and 1985. Variations in ICF-MR use and costs across States are also discussed, since States differ enormously in ICF-MR utilization rates, in the types of facilities which are certified to provide ICF-MR services, and in the amount of money which is spent for ICF-MR care.

Better information about the ICF-MR program is needed because it is the primary Federal funding source for services to developmentally disabled persons. It is also a program which many believe requires substantial policy modification in order to better reflect and adapt to the changes taking place in the financing and delivery of services to developmentally disabled individuals and their families in general. Care which has traditionally been provided in large, publicly-owned and operated institutions is being replaced by residential care in small, privately-operated facilities integrated into local communities, and through increased supports to families caring for developmentally disabled children in their own homes.

5.1 ICF-MR Recipients: 1975-1985

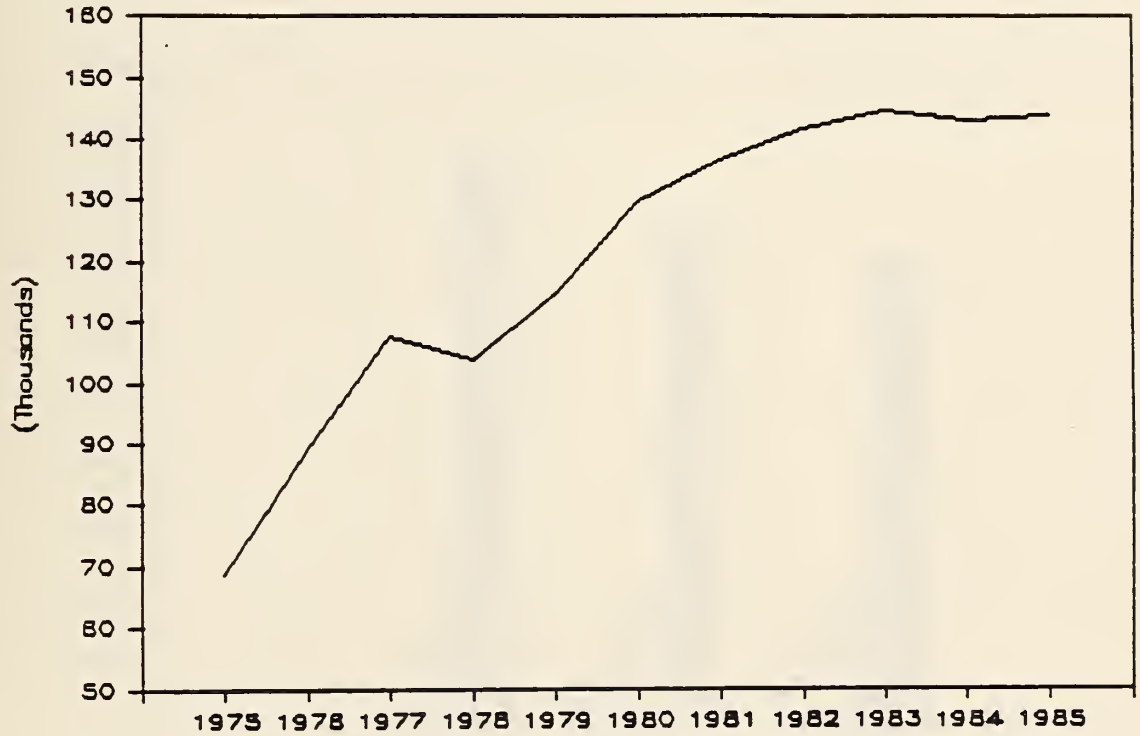
Between 1975 and 1980, the ICF-MR program experienced rapid growth as an increasing number of States certified their publicly-operated institutions as ICFs-MR. During this five-year period, the number of ICF-MR recipients approximately doubled, from 68,706 to 129,753 (Exhibit 5-1). By 1980, all but four States (Hawaii, Maine, North Dakota and Wyoming) had at least one ICF-MR certified facility. By 1982, results of a national survey of residential care facilities for the mentally retarded estimated that there were only about 5,000 persons left in State-operated institutions who were not in ICF-MR certified beds (Lakin et al, 1985).

Since 1980, the number of ICF-MR recipients has gradually stabilized. Between 1982 and 1985, the number of ICF-MR recipients ranged between 142,000 and 145,000 recipients. Thus, the 1975 to 1985 period can be divided into two distinct phases--a phase of extremely rapid growth during the first five years, followed by a phase of slowed growth, to the point where it appears as if the number of ICF-MR recipients had reached a peak, or at least a plateau, by the mid 1980s.

Relative stability in the size of the ICF-MR population in recent years masks an important trend in the ICF-MR program, however--a shift from large-scale, publicly-operated ICFs-MR to small-scale, privately-operated facilities. Exhibit 5-2 shows the distribution of ICF-MR beds, by facility size, in the years 1977, 1982 and 1985. In 1977, 88% of all ICF-MR recipients

EXHIBIT 5-1

ICF-MR RECIPIENTS: 1975 - 1985

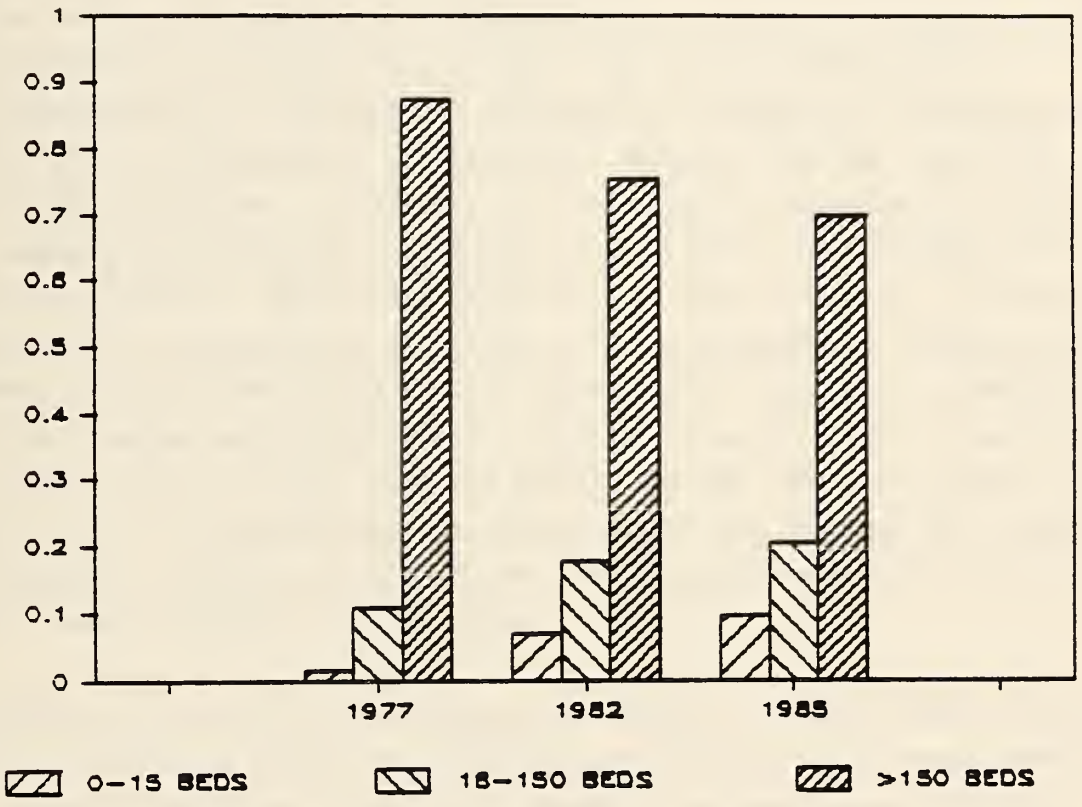


Source: Edited HCFA 2082 data, Bureau of Data Management and Strategy.

EXHIBIT 5-2

DISTRIBUTION OF ICF-MR BEDS BY FACILITY SIZE

1977 - 1985



Source: Lakin et al, 1985; and Laudicina and Burwell, 1987.

resided in large-scale facilities of 150 beds or greater, while less than 2% were in small-scale, community-based facilities of 15 beds or less. By 1985, the proportion of recipients residing in large-scale facilities had dropped to 70%, while the number of recipients in small facilities had increased sixfold, to about 14,000 recipients.

Thus, even as States moved quickly to certify their public institutions as ICFs-MR during the mid to late 1970s, there were also concurrent efforts to develop small-scale, usually privately-operated, ICFs-MR as alternatives to the publicly-operated residential care system. The trend toward smaller residential facilities reflects the programmatic philosophy of "normalization" in the field of developmental disabilities. Normalization has both clinical and ethical foundations. Clinically, the philosophy of normalization holds that learning and behavioral development is more effectively reinforced in normal environments. Small-scale facilities are more conducive to the kind of individualized training which is necessary for developmentally disabled persons to learn new skills and function more independently. Ethically, normalization holds that persons with developmental disabilities have a right to experience as "normal" a life as their abilities permit. At the same time, however, high quality care is not inherent to small-scale facilities, nor bad care inherent to large ones. Examples of good and bad care in ICF-MR certified facilities can be found in facilities of all sizes.

Between 1977 and 1982, the changing distribution of ICF-MR beds in large and small facilities simply reflected more rapid bed growth in small ICFs-MR than in large facilities. Since 1982, however, the total number of ICF-MR recipients has remained relatively constant, and there has been an actual substitution of beds in small facilities for beds in larger facilities. Many States have been decertifying ICF-MR beds in their publicly-operated institutions as the populations in these institutions have declined, and a few States have been successful in closing entire facilities outright.

5.2 Characteristics of ICF-MR Recipients

Most individuals residing in ICFs-MR have substantial mental and developmental impairments. According to a national survey conducted in 1982,

half of all ICF-MR recipients were profoundly retarded (Lakin et al, 1985). Profoundly retarded persons generally have IQs below 20 (more than five standard deviations from the mean), and demonstrate the mental capacities of children between birth and 3 years of age (a considerable range). Another 25% of the ICF-MR population were severely retarded, generally persons with IQs of between 20 and 35. The remaining 25% of ICF-MR recipients were moderately or mildly retarded.

Many ICF-MR recipients have significant deficits in one or more basic living skills areas. Approximately 25% are non-ambulatory; 30% are not toilet-trained; 46% need assistance in dressing; and 44% are not able to communicate verbally (Lakin et al, 1985). A considerable proportion have behavioral problems related to their developmental deficits, and/or concomitant medical conditions (Minahan, 1986).

The age distribution of ICF-MR recipients does not reflect the age distribution of the general population, as shown in Exhibit 5-3. In 1982, 22% of the total U.S. population was under the age of 15, but only 7% of all ICF-MR recipients were in this age group. This pattern reflects the recent decline in the number of mentally retarded children who are placed outside their natural homes. The expansion of special education programs and supportive services to families with mentally retarded children, in combination with attitudinal changes about out-of-home placements, has led to a significant increase in the number of families who elect to keep their children at home.

Exhibit 5-3

Age Distribution of ICF-MR Recipients and Total U.S. Population in 1982

Age Group	ICF-MR Recipients	Total U.S.
0 - 4	0.6%	7.5%
5 - 9	2.0	6.9
10 - 14	4.7	7.8
15 - 21	15.3	12.2
22 - 39	49.6	29.5
40 - 62	23.2	22.8
63 and over	4.6	13.3
	100.0%	100.0%

Source: Lakin, Hill and Bruininks, 1985; and Bureau of the Census, 1983.

At the other end of the age continuum, there is a similar pattern. While 13.3% of the general U.S. population was over the age of 62 in 1982, only 4.6% of the ICF-MR population was over 62. The relatively small percentage of aged ICF-MR recipients may reflect the use of alternative residential settings, particularly nursing homes, for aged developmentally disabled individuals (Burwell et al, 1986).

Thus, almost half of all ICF-MR recipients are young adults, between the ages of 22 and 39. About 55% of all recipients are male, reflecting the higher incidence of mental retardation among males in the overall population.

5.4 Expenditures for ICF-MR Care: 1975-1985

Medicaid expenditures for ICF-MR care from 1975 to 1985 reflect the growth in recipients--there was a five-year period of extremely high growth between 1975 and 1980, followed by a period of substantial moderation in expenditure growth between 1980 and 1985. Exhibits 5-4 and 5-5 present ICF-MR expenditures from 1975 to 1985 in nominal and real dollars. From 1975 to 1980, expenditures for ICF-MR care rose from $380 million to $2.6 billion, an annual compound rate of growth (ACRG) of 46.9%. In comparison, total Medicaid expenditures grew at an ACRG of 13.9% over the same period. ICF-MR expenditures, in fact, accounted for 20% of the total increase in Medicaid costs over this five-year period.

Since most of the growth in ICF-MR expenditures between 1975 and 1980 reflects the certification of State institutions for the retarded as ICFs-MR, the fiscal impact of the ICF-MR program on State budgets was not as severe as on the Federal budget. Institutions which had previously been funded entirely with State dollars were now being funded under Medicaid at rates of Federal participation ranging from 50 to 77%. Thus, increases in State Medicaid budgets for ICF-MR care were to some degree offset by decreases in State MR/DD budgets for public institutions. However, the certification of State institutions as ICFs-MR did not simply represent a shifting of costs from States to the Federal government. As the original legislation intended, most States were required to make significant capital investments in their public institutions in both physical improvements and staffing in order to bring their institutions into compliance with ICF-MR certification standards. One study

EXHIBIT 5-4

ICF-MR EXPENDITURES: 1975 - 1985

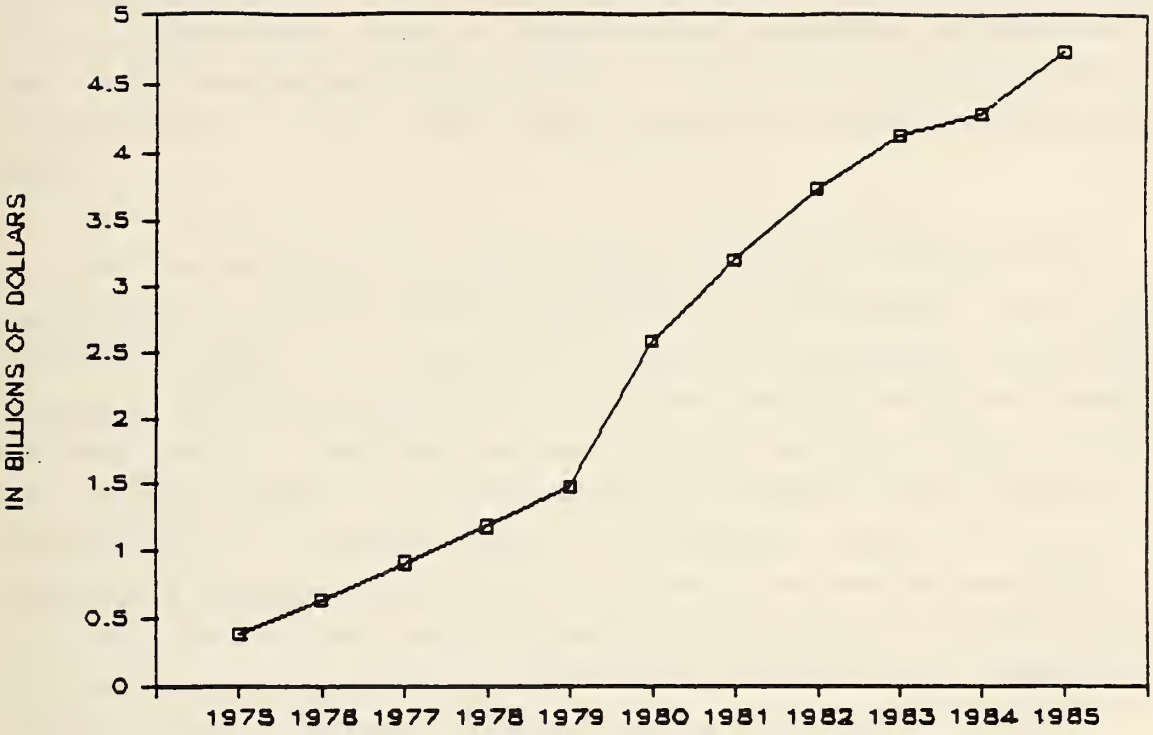
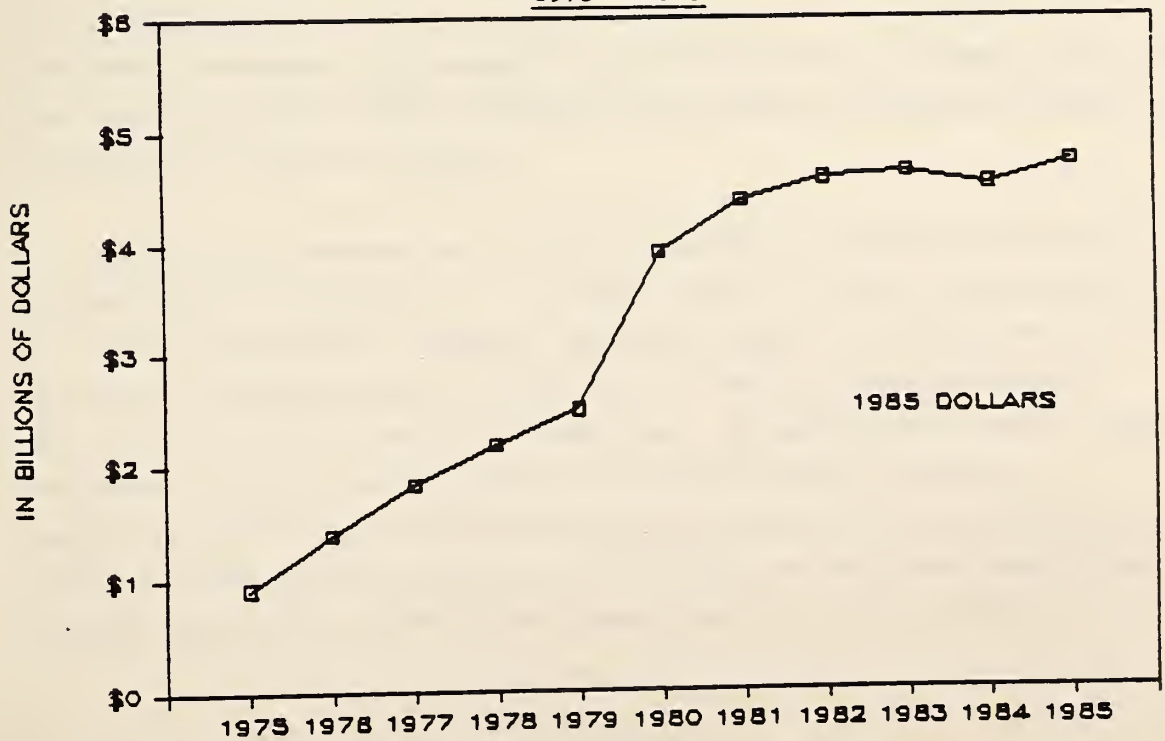


EXHIBIT 5-5

ICF-MR EXPENDITURES IN 1985 DOLLARS

1975 - 1985



Source: Edited HCFA 2082 data, Bureau of Data Management and Strategy.

estimated that States invested over a billion dollars between 1977 and 1980 in physical improvements alone for State-operated residential facilities, and that more than three-fourths of these capital outlays were devoted exclusively to bringing facilities into ICF-MR program compliance (Gettings and Mitchell, 1980).

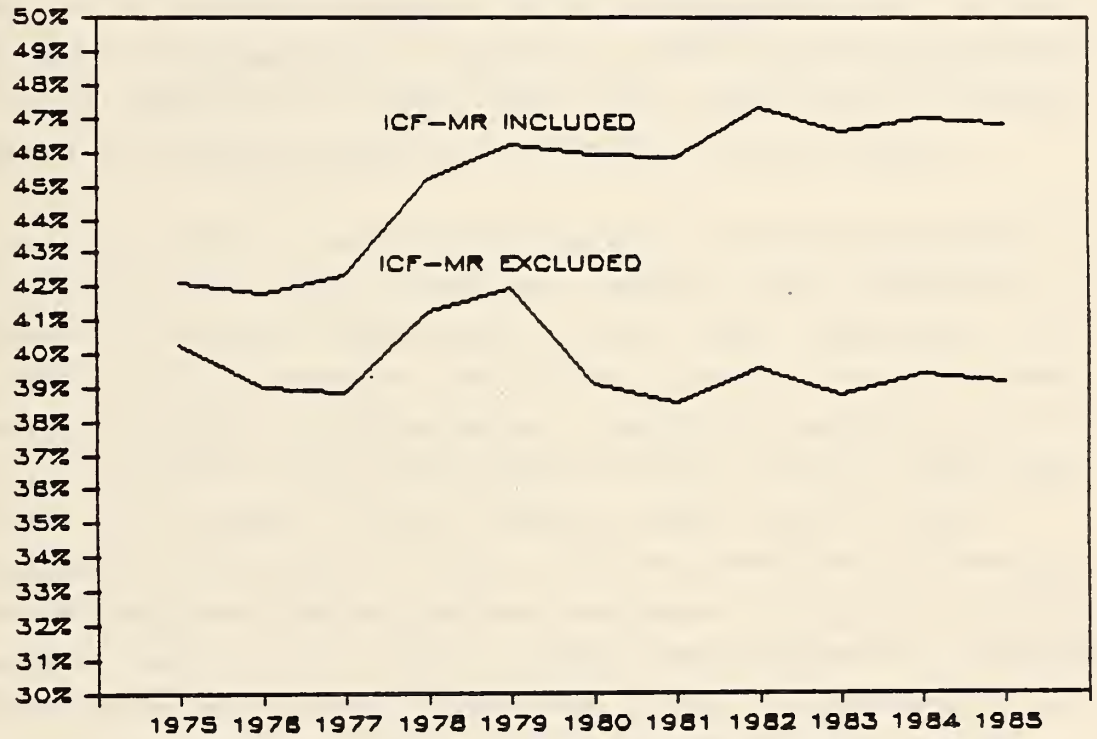
Much has been made of the fact that long-term care expenditures are accounting for an ever-increasing proportion of total Medicaid costs. However, as shown in Exhibit 5-6, this trend is entirely attributable to the ICF-MR program. If ICF-MR expenditures are excluded from the ratio (both numerator and denominator), other long-term care costs (primarily nursing home care for the elderly) remained a relatively constant proportion of total Medicaid expenditures over the period (note 2). If Medicaid long-term care costs for elderly and developmentally disabled recipients are examined separately, one finds that nursing home costs for aged Medicaid recipients increased at about the same rate as the rest of Medicaid between 1975 and 1985. Contrary to popular belief, increases in Medicaid nursing home costs for elderly beneficiaries have been quite moderate over the last decade.

Since 1980, expenditures for ICF-MR care have moderated significantly (Exhibits 5-4 and 5-5). Whereas expenditures rose almost 50% per year prior to 1980, they increased at an average rate of 12.8% per year between 1980 and 1985, only slightly faster than Medicaid expenditures as a whole. As previously discussed, this moderation in expenditures is primarily due to the fact that States had largely completed the process of certifying their public institutions by the early 1980s.

However, this moderation in ICF-MR expenditures does not mean that the ICF-MR program is presently in a "steady state." In fact, the program is in the midst of significant change. The major dynamic in the program since 1980 has been the substitution of ICF-MR beds in small, privately-operated facilities for beds in public institutions. Recognizing this shift, HCFA began requesting States to submit claims for ICF-MR services provided in privately-operated facilities and publicly-operated facilities separately in FY 1985. In 1985, States spent about $3.9 billion on their own publicly-operated ICFs-MR, about 82% of total ICF-MR expenditures, and the remaining 18% on

EXHIBIT 5-6

PERCENT OF MEDICAID SPENT ON NURSING HOME CARE
INCLUDING AND EXCLUDING ICF-MR CARE
1975 - 1985



Source: Edited HCFA 2082 data, Bureau of Data Management and Strategy.

privately-operated facilities, about $850 million. In the first quarter of FY 1986, however, expenditures for publicly-operated facilities had dropped to 78% of total costs, with expenditures for private facilities increasing to 22%.

5.5 Costs Per ICF-MR Recipient

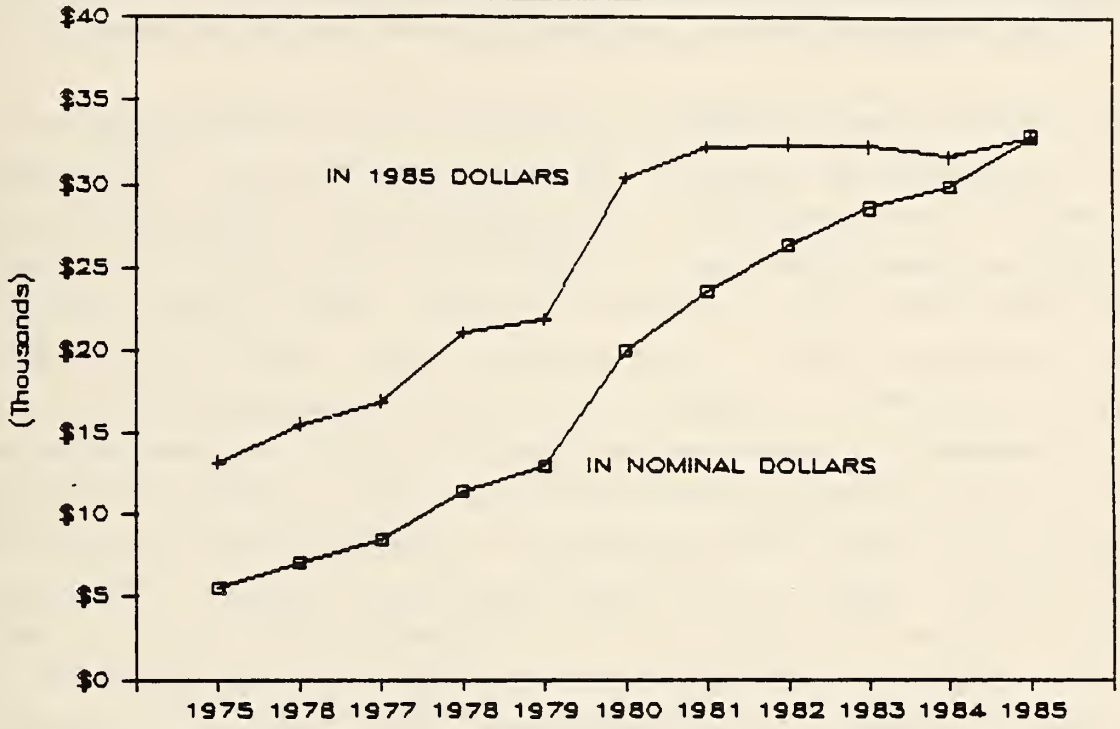
Increased expenditures for ICF-MR care from 1975 to 1985 were not only attributable to the increasing number of residential facilities certified as ICFs-MR, but to dramatic increases in ICF-MR reimbursement rates. As shown in Exhibit 5-7, the average cost per recipient of ICF-MR care more than doubled in real dollars between 1975 and 1980. Since 1980, average costs per recipient have generally reflected increases in the medical care price index.

A number of factors account for the doubling of ICF-MR reimbursement rates during the late 1970s. First, States were required to make substantial improvements in both the physical plants of their public institutions, and in the staffing ratios within these institutions, in order to bring them into compliance with Federal ICF-MR standards. When ICF-MR regulations were first issued in January 1974, States were given until June of 1977 to bring their facilities up to standard, and were allowed to make claims for ICF-MR reimbursement in the interim, as long as they were demonstrating "good faith" efforts to bring their institutions into compliance. In March of 1977, when it was apparent that many States were not going to meet this deadline, additional regulations were issued which allowed States to apply for extensions of up to three additional years for physical improvements and up to one year for staffing improvements (Gettings, 1986). Thus, increased costs per recipient of ICF-MR care during the late 1970s partly reflects the shift from non-certified institutions to certified ones. States were making considerable investments in their public institutions to bring them into ICF-MR compliance, and these investments were reflected in higher ICF-MR reimbursement rates.

At the same time, many States were the targets of successful litigation by advocacy groups, which sometimes mandated staffing ratios and facility standards over and above that required by Federal ICF-MR regulations. The costs of complying with these judicial decrees were also eventually reflected in ICF-MR reimbursement rates. A final factor contributing to the increase in

EXHIBIT 5-7

ICF-MR COSTS PER RECIPIENT
1975 - 1985



Source: Edited HCFA 2082 data, Bureau of Data Management and Strategy.

costs per ICF-MR recipient is that States became increasingly sophisticated in learning what indirect costs could be included in the reimbursement rate for their public institutions. For example, since many public institutions were built 50 to 100 years previously, some States initially only made ICF-MR claims for the operating costs of their institutions, not for any capital costs.

The average annual cost per recipient of ICF-MR care was $32,960 in 1985 (Exhibit 5-8). In comparison, the average annual cost per recipient of ICF and SNF care was $7,872 and $9,280 respectively. Two factors account for the higher cost of ICF-MR care. First, there is less turnover among the ICF-MR population than among other long-term care users. In 1985, the average ICF-MR recipient used 327 days of care. A recent study of ICF-MR recipients in three States showed that about three-fourths of all users of ICF-MR care in a given year are persons who reside in the facility from January 1 to December 31 (Burwell et al, 1986). Second, the average Medicaid payment per day of ICF-MR care was $101 in 1985, compared to $45 per day for SNF care, and $32 per day for ICF care. Although ICF-MR reimbursement rates are higher than ICF or SNF rates, part of this cost difference is also attributable to the fact that ICF and SNF recipients are more likely to have outside sources of income which they contribute to the cost of their nursing home care as a spend-down liability, thereby reducing the average Medicaid payment amount per recipient.

Exhibit 5-8

Average Annual Medicaid Payment Per Recipient, Average Length of Stay, and Average Medicaid Payment Per Day for ICF-MR, ICF and SNF Recipients: 1985

	Average Annual Cost Per Recipient	Average Length of Stay	Average Medicaid Payment Per Day
ICF-MR	$32,960	327 days	$101
ICF	$7,872	248 days	$32
SNF	$9,280	205 days	$45

Source: Edited HCFA 2082 data, Office of Data Management and Strategy, 1986.

5.6 Other Medicaid and Medicare Costs of ICF-MR Recipients

What other Medicaid-covered services do ICF-MR recipients use besides ICF-MR care? A recent study in three States, which examined total Medicaid costs for ICF-MR recipients, found that ICF-MR care accounted for between 95-99% of total Medicaid costs for ICF-MR users (Burwell et al, 1986). Average non-ICF-MR costs for users of ICF-MR care were $291 in Georgia, $355 in Michigan, and $1,432 in California in 1982. Hospital care accounted for most of these non-ICF-MR costs. Distributional analyses found that a very small percentage of ICF-MR recipients accounted for most of these other Medicaid costs.

Low utilization of other Medicaid-covered services by ICF-MR recipients may be partly attributable to the fact that specialized medical services are often provided by on-site staff, the costs of which are encompassed within the overall ICF-MR reimbursement rate. Another factor may be that many ICF-MR recipients may still be covered by their parents' private health benefit plans (if they are still eligible as dependents under their parents' plan) for medical services not provided within the ICF-MR itself. A recent study of 229 ICF-MR recipients scheduled for community placement in Massachusetts showed that the recipients had "a multitude of serious medical conditions and physical disabilities in addition to their mental retardation" (Minihan, 1986). Ninety-two percent of the population had a need for at least one specialty physician service, and several medical specialties essential to the care of the study population were found not to be available in the local community.

Between 30-40% of ICF-MR recipients, about 40,000 persons, are also eligible for Medicare (Burwell et al, 1986). Most of these "dual enrollees" are persons who receive Social Security Disability Insurance (SSDI) under the category of Adult Disabled Children (ADC). Adult Disabled Children are persons who qualify for SSDI benefits as dependents of retired or deceased Social Security beneficiaries even though they themselves have never contributed to the OASDI trust fund, because their disability began before the age of 22. Although data on the Medicare costs of ICF-MR recipients who are dual enrollees are not specifically available, a recent study shows that average Medicare costs for all Adult Disabled Children, about 25% of whom are ICF-MR recipients,

are quite low--about $635 in 1985 dollars (Lubitz and Pine, 1986). Thus, the two studies cited above suggest that other Medicaid and Medicare costs for ICF-MR recipients are low in comparison to the cost of ICF-MR care itself. A reasonable estimate is that other Medicaid and Medicare costs add about $1-2,000 to the $32,960 average annual cost of ICF-MR care per recipient.

ICF-MR recipients who receive SSDI payments or who have other sources of outside income must contribute to the cost of their care. Like other Medicaid recipients in long-term care facilities, all income in excess of a monthly $25 personal needs allowance is considered a spend-down liability against the cost of ICF-MR care. Available data on the spend-down liabilities of ICF-MR recipients in two States, Michigan and California, showed that recipients who had a spend-down obligation contributed an average of about $2,600 annually to the cost of their care in 1982 (Burwell et al, 1986). However, these "private" contributions reduced what States would otherwise have paid for ICF-MR care by only about 4%. It is important to recognize that there are hardly any "private pay" clients in ICF-MR facilities as there are in ICFs and SNFs, since parental income is not deemed available to ICF-MR recipients in determining eligibility for Medicaid. Virtually all ICF-MR recipients are Medicaid recipients, and other than client SSDI income and, in rare instances, income which clients receive from trust accounts, Medicaid is the sole payer for ICF-MR care (note 2).

5.7 ICF-MR Utilization Patterns Across States

ICF-MR utilization rates vary enormously across States. In FY 1985, the national utilization rate was 60.3 recipients per 100,000 population (Exhibit 5-9). At the State level, utilization rates varied from 13.3 recipients per 100,000 population in West Virginia to 186.2 recipients per 100,000 in Minnesota, a difference of fourteenfold.

Cross State differences in ICF-MR utilization rates are attributable to two major factors: 1) the total supply of out-of-home residential care beds for developmentally disabled persons in the State (in both ICF-MR certified and non-certified facilities); and 2) the percentage of residential care beds in a State which are certified as ICF-MR beds. A 1982 survey of all types of

EXHIBIT 5-9

ICF-MR RECIPIENTS PER 100,000 STATE POPULATION: 1982 AND 1985

State	STATES RANKED BY 1985 UTILIZATION RATE 1985	1982	CHANGE	State	STATES RANKED BY 1982-1985 CHANGE 1982-1985
United States	60.3	61.2	-1.0	United States	-1.0
Minnesota	186.2	179.1	7.1	North Dakota	87.8
Louisiana	127.4	105.6	21.9	Rhode Island	31.8
Rhode Island	120.2	88.5	31.8	Dist. Columbia	30.0
South Dakota	105.6	117.4	-11.8	Louisiana	21.9
New York	100.2	94.0	6.2	Oklahoma	19.0
North Dakota	94.7	7.0	87.8	Massachusetts	14.5
Kansas	93.1	91.9	1.2	Ohio	11.2
Dist. Columbia	89.6	59.6	30.0	Mississippi	7.5
Utah	84.3	79.8	4.4	Minnesota	7.1
Texas	78.2	87.7	-9.4	Florida	7.1
Oklahoma	74.4	55.4	19.0	West Virginia	6.4
South Carolina	74.3	74.2	0.1	North Carolina	6.2
Illinois	74.1	70.1	4.0	New York	6.2
Delaware	71.1	77.3	-6.3	Iowa	5.2
Pennsylvania	70.2	74.6	-4.4	Utah	4.4
Ohio	69.3	58.0	11.2	New Hampshire	4.0
Oregon	69.1	94.8	-25.8	Illinois	4.0
Washington	64.4	70.3	-5.8	Maine	3.5
Iowa	64.4	59.2	5.2	Tennessee	2.3
Mississippi	63.1	55.5	7.5	Kansas	1.2
Arkansas	61.6	62.6	-1.0	Montana	0.2
Maine	60.9	57.4	3.5	South Carolina	0.1
Massachusetts	60.7	46.2	14.5	Wyoming	0.0
Tennessee	58.0	55.7	2.3	Indiana	-0.1
Virginia	56.4	84.2	-27.7	Alabama	-0.3
Nebraska	55.7	64.6	-9.0	New Mexico	-0.3
New Jersey	53.3	69.4	-16.2	Connecticut	-0.9
Vermont	52.7	79.4	-26.7	Arkansas	-1.0
Idaho	50.6	53.5	-2.9	Wisconsin	-1.5
Wisconsin	49.9	51.4	-1.5	Nevada	-2.1
North Carolina	49.3	43.1	6.2	Georgia	-2.8
Colorado	48.7	64.8	-16.1	Idaho	-2.9
New Mexico	43.0	43.4	-0.3	California	-4.2
Maryland	42.5	47.9	-5.4	Pennsylvania	-4.4
Connecticut	41.2	42.1	-0.9	Maryland	-5.4
Michigan	40.4	48.2	-7.8	Washington	-5.8
Indiana	39.9	40.1	-0.1	Delaware	-6.3
Missouri	37.9	48.6	-10.7	Hawaii	-7.5
New Hampshire	37.5	33.4	4.0	Michigan	-7.8
California	36.9	41.2	-4.2	Nebraska	-9.0
Alabama	36.5	36.8	-0.3	Kentucky	-9.1
Montana	34.4	34.2	0.2	Texas	-9.4
Kentucky	33.9	43.0	-9.1	Missouri	-10.7
Hawaii	31.4	38.9	-7.5	South Dakota	-11.8
Georgia	29.3	32.1	-2.8	Colorado	-16.1
Florida	28.3	21.2	7.1	New Jersey	-16.2
Alaska	24.0	65.3	-41.3	Oregon	-25.8
Nevada	21.9	24.0	-2.1	Vermont	-26.7
West Virginia	13.3	6.9	6.4	Virginia	-27.7
Wyoming	0.0	0.0	0.0	Alaska	-41.3

Sources: Edited HCFA 2082 data, Bureau of Data Management and Strategy; and Bureau of the Census, 1986.

residential care facilities for the mentally retarded (both ICF-MR facilities and non-ICF-MR facilities) conducted by the Center for Residential and Community Services at the University of Minnesota found that overall placement rates per 100,000 population varied from 34 in Nevada to 184 in North Dakota (Lakin et al, 1985). The national placement rate was 105 mentally retarded persons in residential care per 100,000 population. Thus, the supply of residential facilities for mentally retarded persons varies enormously from State to State. In States which have a low supply of residential care beds, presumably a higher percentage of mentally retarded persons remain at home or are inappropriately placed in other types of residential settings, such as nursing homes or mental institutions.

However, States also vary enormously in their use of the ICF-MR benefit as a financing mechanism for residential care. As shown in Exhibit 5-10, in some States virtually all residential facilities are certified as ICFs-MR, while in others, the ICF-MR program finances only a small percentage of residential facilities for the mentally retarded. Residential facilities not certified as ICF-MR facilities include group homes, board and care homes, foster homes, and supervised apartment programs. These facilities are generally financed by client SSI/SSP income, State-only funds provided by the State MR/DD agency, local contributions such as United Way, and occasionally HUD direct loan and rental subsidies. Non-ICF-MR residential facilities are generally smaller than ICF-MR facilities, less expensive, and serve less disabled clients (Lakin et al, 1985). However, some States have used the ICF-MR program to finance a broad range of residential facilities, from small scale group homes to large-scale institutions (ICF-MR program regulations only require that ICF-MR facilities have <u>at least</u> six beds). Minnesota, Michigan, New York, Indiana, Rhode Island, and Louisiana are six States which have used the ICF-MR benefit extensively as a financing mechanism for small-scale residential facilities of 15 beds or less. This largely explains why these States have the highest ICF-MR utilization rates, as shown in Exhibit 5-9.

5.8 Variations in Expenditures for ICF-MR Care Across States

As ICF-MR utilization rates vary widely from State to State, so do expenditures for ICF-MR care. Some States have limited their use of the ICF-MR

EXHIBIT 5-10

PROPORTION OF TOTAL RESIDENTIAL CARE BEDS WHICH ARE ICF-MR CERTIFIED, BY STATE: 1982

State	Percent
Minnesota	98.1%
Louisiana	95.9%
Utah	88.8%
Texas	88.6%
Rhode Island	87.1%
Virginia	85.1%
Arkansas	83.8%
Oregon	77.3%
Alabama	75.6%
Colorado	75.3%
South Carolina	73.2%
Georgia	72.8%
Washington	72.3%
Kansas	72.3%
Indiana	70.6%
Tennessee	67.4%
Kentucky	67.2%
Delaware	67.1%
New Mexico	65.4%
Illinois	64.0%
North Carolina	63.0%
Wisconsin	62.4%
Nebraska	60.4%
Mississippi	60.3%
Oklahoma	59.9%
South Dakota	59.3%
Massachusetts	59.1%
Nevada	58.1%
Maryland	57.0%
Idaho	56.0%
Ohio	55.6%
Pennsylvania	55.2%
New Jersey	50.0%
District of Columbia	49.2%
Vermont	48.2%
Alaska	47.6%
Hawaii	45.2%
California	44.8%
Maine	43.0%
Montana	38.1%
Iowa	36.8%
Michigan	36.0%
New Hampshire	35.9%
Connecticut	35.1%
Missouri	30.0%
Florida	26.4%
New York	22.0%
North Dakota	17.7%
West Virginia	17.1%
Arizona	.0%
Wyoming	.0%

Source: Lakin et al, 1985.

benefit as a means of gaining Federal participation for the financing of State institutions. In 1982, 13 States had four or less ICF-MR certified facilities, including Wyoming, which had none (Lakin et al, 1985). Other States have used the ICF-MR benefit much more extensively, not only as a means of gaining Federal financial participation for the costs of their public institutions, but also as a means of financing a wide range of privately-operated facilities for the developmentally disabled.

These variations in State approaches to the ICF-MR program are reflected in the wide variation in levels of expenditures for ICF-MR care across States. Exhibit 5-11 presents statistics on State expenditures for ICF-MR care, including: nominal expenditure levels in 1980 and 1985; per capita expenditures (expressed in dollars spent on ICF-MR care per State resident) in 1980 and 1985; change in per capita expenditures between 1980 and 1985; average cost per day of ICF-MR care; number of ICF-MR recipients per 100,000 State population, average annual costs per ICF-MR recipient; and ICF-MR expenditures as a percentage of total State Medicaid expenditures.

States are ranked by the amount spent for ICF-MR care per State resident in 1985. New York, which ranked first, spent $54.40 for ICF-MR services per State resident. The variation across States in expenditure levels, even after adjusting for State population size, is quite evident. Per State resident, New York spent over forty times what West Virginia spent for ICF-MR care in 1985. In fact, New York spent more for ICF-MR care in FY 1985 than 40 States spent on their entire Medicaid programs.

Although nominal expenditures for ICF-MR care increased from $2.6 to $4.7 billion between 1980 and 1985, expenditures per capita, adjusted for inflation, increased by only 14%, from $17.44 to $19.86. Fifteen States actually spent less for ICF-MR care per capita, adjusted for inflation, in 1985 than in 1980. For example, New Jersey spent $27.49 per State resident for ICF-MR care in 1980 (in 1985 dollars), and only $21.98 in 1985, a 20% decline. Thus, over this five period, all States were not following a similar trend. Some States continued to expand their ICF-MR programs; other States had reduced expenditures for ICF-MR care in real terms.

Exhibit 5-11

STATE EXPENDITURES FOR ICF-MR CARE

State	ICF-MR EXPENDITURES 1980	ICF-MR EXPENDITURES 1985	EXPENDITURES PER STATE RESIDENT 1980*	EXPENDITURES PER STATE RESIDENT 1985	INCREASE/ DECREASE 1980-85	ICF-MR COST PER DAY 1985	ICF-MR RECIPIENTS PER 100,000 POP 1985	ICF-MR COSTS PER RECIP 1985	ICF-MR $$ AS PERCENT OF TOTAL MEDICAID $$ 1985
United States	$2,599,807,121	$4,741,114,585	$17.44	$19.86	$2.42	$101	60.3	$32,960	12.7%
New York	558,694,000	967,428,000	48.37	54.40	6.04	172	100.2	54,283	12.7%
Minnesota	116,214,494	202,213,106	43.34	48.23	4.89	72	186.2	25,898	20.2%
Rhode Island	23,328,400	43,868,516	37.44	45.32	7.88	114	120.2	37,688	17.5%
Massachusetts	121,437,511	228,845,654	32.17	39.31	7.13	205	60.7	64,774	16.0%
Dist. Columbia	9,491,204	21,487,810	22.61	34.33	11.71	125	89.6	38,303	6.9%
Louisiana	65,638,026	136,985,194	23.72	30.57	6.85	71	127.4	23,990	18.9%
Pennsylvania	205,699,735	344,664,666	26.35	29.08	2.72	119	70.2	41,441	19.2%
North Dakota	0	18,318,261	0.00	26.74	26.74	98	94.7	28,225	15.7%
Vermont	9,453,567	12,800,197	28.12	23.93	-4.19	130	52.7	45,391	14.3%
Washington	52,342,000	101,514,926	19.25	23.02	3.77	110	64.4	35,732	17.4%
South Dakota	11,786,774	15,874,926	25.93	22.42	-3.51	64	105.6	21,223	16.8%
New Jersey	133,194,189	166,248,451	27.49	21.98	-5.50	122	53.3	41,283	14.5%
Maine	0	24,884,408	0.00	21.38	21.38	98	60.9	35,098	10.7%
Iowa	39,428,797	60,953,643	20.57	21.14	0.57	97	64.4	32,841	16.9%
Kansas	34,808,186	49,483,654	22.38	20.20	-2.18	61	93.1	21,703	19.3%
Alaska	6,074,196	10,147,278	22.97	19.48	-3.49	NA	24.0	81,178	15.3%
Oregon	36,452,497	51,992,014	21.04	19.35	-1.69	82	69.1	28,013	21.8%
Illinois	70,712,000	215,970,087	9.41	18.72	9.32	77	74.1	25,271	13.1%
Connecticut	23,794,000	59,373,051	11.64	18.71	7.07	151	41.2	45,358	10.0%
Arkansas	25,655,369	42,381,035	17.06	17.97	0.91	92	61.6	29,188	11.8%
North Carolina	44,466,053	111,953,929	11.49	17.90	6.41	113	49.3	36,313	17.3%
Ohio	69,573,154	186,708,927	9.79	17.38	7.58	73	69.3	25,089	10.6%
Michigan	130,804,000	157,208,370	21.47	17.30	-4.17	130	40.4	42,836	10.4%
Virginia	54,186,380	94,968,072	15.40	16.64	1.24	83	56.4	29,493	17.4%
Oklahoma	27,540,867	53,675,015	13.84	16.26	2.42	76	74.4	21,855	11.7%
Texas	159,781,381	265,693,713	17.07	16.23	-0.84	62	78.2	20,746	18.8%
Idaho	7,254,343	15,983,568	11.68	15.90	4.22	88	50.6	31,402	20.9%
South Carolina	30,822,576	53,057,144	15.01	15.85	0.85	62	74.3	21,334	17.1%
Delaware	6,517,097	9,833,868	16.68	15.81	-0.87	65	71.1	22,249	13.9%
Colorado	25,730,385	49,117,047	13.53	15.20	1.67	86	48.7	31,205	15.6%
Maryland	44,188,000	66,361,435	15.93	15.11	-0.82	NA	42.5	35,583	11.4%
Nebraska	15,217,379	24,089,931	14.73	15.00	0.27	78	55.7	26,946	14.4%
New Hampshire	5,084,364	14,880,470	8.39	14.91	6.52	NA	37.5	39,787	12.6%
Utah	16,028,349	23,978,567	16.68	14.58	-2.10	55	84.3	17,301	21.9%
Wisconsin	56,090,080	68,139,071	18.12	14.27	-3.85	91	49.9	28,582	7.2%
Tennessee	44,018,768	63,438,297	14.57	13.32	-1.25	73	58.0	22,968	11.0%
Alabama	13,863,000	49,319,263	5.41	12.27	6.85	98	36.5	33,596	13.1%
New Mexico	6,493,021	17,294,130	7.57	11.93	4.35	86	43.0	27,715	11.7%
Kentucky	20,550,512	39,717,321	8.53	10.66	2.13	91	33.9	31,422	7.4%
California	141,050,000	277,575,882	9.06	10.53	1.47	92	36.9	28,499	6.9%
Missouri	30,532,825	52,325,352	9.44	10.40	0.97	96	37.9	27,424	10.0%
Georgia	38,653,774	61,749,501	10.75	10.33	-0.42	100	29.3	35,285	8.1%
Florida	13,547,703	116,325,502	2.11	10.23	8.12	123	28.3	36,115	12.3%
Montana	4,523,665	8,087,688	8.74	9.79	1.05	94	34.4	28,478	8.5%
Nevada	3,665,375	8,769,109	6.96	9.37	2.40	132	21.9	42,776	13.4%
Mississippi	9,719,600	23,210,257	5.86	8.88	3.02	45	63.1	14,084	8.5%
Hawaii	9,006,000	8,824,401	14.19	8.37	-5.81	104	31.4	26,660	6.3%
Indiana	25,784,804	40,787,772	7.14	7.42	0.28	62	39.9	18,582	5.5%
West Virginia	908,721	2,606,106	0.71	1.35	0.64	41	13.3	10,101	1.5%

*In 1985 dollars.

Source; Edited HCFA 2082 data, Bureau of Data Management and Strategy; and Bureau of the Census, 1986.

There was also considerable variation in the average cost per day of ICF-MR care across States, ranging from $41 per day in West Virginia to $205 per day in Massachusetts. Both the number of ICF-MR recipients per 100,000 State population ($r = .759$, $p < .001$) and the average cost per day of ICF-MR care ($r = .475$, $p < .001$) were highly correlated with expenditures per State resident, but they were not correlated with each other. In fact, there was a negative, though non-significant, correlation between recipient rates and average cost per day ($r = -.134$). In other words, States which had lower utilization rates paid slightly more per day of ICF-MR care than States with higher utilization levels. This may be because States with lower utilization levels have generally limited their ICF-MR programs to their large public institutions, which are more expensive, and to more severely disabled clients.

The average annual cost per ICF-MR recipient is a function of: a) the average cost per day of care; and b) the average number of days of care used annually per recipient. Average annual costs per recipient ranged from $10,101 in West Virginia to $81,178 in Alaska, although the majority of States fell into a range between $25,000 and $40,000 per year.

The last column in Exhibit 5-11 shows State expenditures for ICF-MR care as a proportion of total State Medicaid expenditures. Four States (Minnesota, Oregon, Idaho, Utah) spent more than 20% of their total Medicaid budget for ICF-MR care. The proportion of total Medicaid expenditures spent for ICF-MR care was highly correlated with per capita expenditure levels ($r = .494$, $p < .001$), indicating that States which spent more for ICF-MR care per State resident also spent more for ICF-MR care as a percentage of total Medicaid expenditures. In other words, high levels of ICF-MR spending per State resident is not explained by total State spending for Medicaid. Expenditures for ICF-MR care appear to be independent of overall Medicaid spending patterns.

Exhibit 5-12 presents the distribution of expenditures for ICF-MR care to public and private providers, according to HCFA 64 reports submitted by States (note 3). These data underreport payments made to private providers, since at least four of the States which reported zero payments to private ICF-MR (Michigan, Tennessee, Wisconsin, and New Hampshire) are known to have privately-operated facilities (Lakin et al, 1985). Nevertheless, Exhibit 5-12

EXHIBIT 5-12

PUBLIC AND PRIVATE EXPENDITURES FOR ICF-MR CARE: FY 1985

State	Public ICF-MR Expenditures FY 1985	Private ICF-MR Expenditures FY 1985	Grand Total FY 1985	Percent Public	Percent Private
United States	3,872,179,857	895,459,568	4,767,639,425	81.2%	18.8%
Hawaii	8,878,336	0	8,878,336	100.0%	0.0%
Maryland	66,361,435	0	66,361,435	100.0%	0.0%
Michigan	157,300,485	0	157,300,485	100.0%	0.0%
Tennessee	15,447,639	0	15,447,639	100.0%	0.0%
Wisconsin	68,001,489	0	68,001,489	100.0%	0.0%
New Hampshire	13,558,762	0	13,558,762	100.0%	0.0%
Delaware	9,873,068	0	9,873,068	100.0%	0.0%
Alabama	60,429,687	510,129	60,939,816	99.2%	0.8%
Montana	7,213,802	97,253	7,311,055	98.7%	1.3%
New Jersey	171,077,040	2,566,364	173,643,404	98.5%	1.5%
Massachusetts	192,215,769	5,595,260	197,811,029	97.2%	2.8%
Georgia	59,878,849	1,888,821	61,767,670	96.9%	3.1%
Connecticut	57,866,242	3,372,786	61,239,028	94.5%	5.5%
California	259,609,076	16,007,042	275,616,118	94.2%	5.8%
Oklahoma	50,224,503	3,450,513	53,675,017	93.6%	6.4%
Missouri	44,306,487	3,278,864	47,585,351	93.1%	6.9%
Arkansas	45,052,105	3,440,966	48,493,072	92.9%	7.1%
South Carolina	48,495,313	3,916,162	52,411,475	92.5%	7.5%
Nevada	8,193,326	790,012	8,983,338	91.2%	8.8%
Virginia	104,711,259	10,102,561	114,813,821	91.2%	8.8%
Oregon	47,031,280	5,880,228	52,911,508	88.9%	11.1%
North Carolina	98,210,404	14,630,456	112,840,860	87.0%	13.0%
South Dakota	13,439,128	2,438,774	15,877,901	84.6%	15.4%
Texas	246,005,217	46,835,322	292,840,539	84.0%	16.0%
New Mexico	14,560,701	2,848,144	17,408,845	83.6%	16.4%
Pennsylvania	285,933,992	56,758,009	342,692,001	83.4%	16.6%
Washington	77,181,860	16,010,520	93,192,380	82.8%	17.2%
North Dakota	15,010,724	3,492,898	18,503,622	81.1%	18.9%
New York	781,238,330	187,030,918	968,269,248	80.7%	19.3%
Iowa	47,745,470	11,728,407	59,473,877	80.3%	19.7%
Illinois	167,496,774	45,262,416	212,759,190	78.7%	21.3%
Kentucky	31,311,285	8,534,878	39,846,163	78.6%	21.4%
Alaska	7,918,828	2,228,450	10,147,278	78.0%	22.0%
West Virginia	2,089,542	639,793	2,729,336	76.6%	23.4%
Kansas	29,394,253	10,945,046	40,339,299	72.9%	27.1%
Idaho	10,976,117	4,512,069	15,488,186	70.9%	29.1%
Utah	20,826,659	8,598,399	29,425,058	70.8%	29.2%
Colorado	41,987,744	18,007,234	59,994,978	70.0%	30.0%
Rhode Island	33,095,742	14,372,393	47,468,136	69.7%	30.3%
Indiana	27,703,056	13,084,719	40,787,775	67.9%	32.1%
Mississippi	14,917,042	8,542,288	23,459,330	63.6%	36.4%
Vermont	7,367,385	4,555,890	11,923,274	61.8%	38.2%
Florida	72,830,884	45,272,555	118,103,439	61.7%	38.3%
Nebraska	13,950,269	10,236,540	24,186,809	57.7%	42.3%
Dist. Columbia	12,603,410	9,476,464	22,079,874	57.1%	42.9%
Louisiana	78,183,431	60,145,080	138,328,511	56.5%	43.5%
Ohio	109,419,887	100,064,272	209,484,159	52.2%	47.8%
Maine	12,260,102	12,639,332	24,899,434	49.2%	50.8%
Minnesota	102,795,670	115,671,339	218,467,009	47.1%	52.9%
Wyoming	0	0	0	—	—

Source: Edited HCFA 64 data, Division of State Agency Financial Management.

indicates that approximately 80% of total payments for ICF-MR care were made to public providers, primarily the States themselves, while approximately 20% of all payments were for privately-operated facilities. In only two States--Maine and Minnesota--did payments for private providers exceed the amount paid to public ICFs-MR. In absolute dollars, New York had developed by far the largest system of privately-operated ICF-MR facilities. New York paid $187 million to private vendors of ICF-MR care in FY 1985.

5.8 Discussion

Although the ICF-MR program appears to have reached a stabilization period in 1985, it is, in fact, entering a new era of change. There are many who believe that the ICF-MR program requires basic structural reform if it is to reflect current programmatic philosophies in the care of developmentally disabled persons. There are those who contend that the current structure of the ICF-MR benefit is not cost-effective, and that better client outcomes could be achieved at lower cost through alternative financing arrangements.

The shift from large-scale public institutions to small-scale privately-operated facilities is creating tensions in the ICF-MR program. The development of small-scale ICFs-MR has allowed many States to achieve significant reductions in the populations of their State institutions. Thus, the total number of ICF-MR recipients has not increased since 1982. However, costs have continued to increase since it has proven difficult for most States to remove dollars from their public institutions as well as clients. Instead, the fixed costs of operating public institutions have become spread over fewer and fewer clients. Consequently, many States have residual populations left in their public institutions, who are being served at an extremely high cost per client. For example, Massachusetts is a State which has been very successful in deinstitutionalizing its State institutions in recent years, but which spent about $65,000 per year for those clients remaining in its State facilities in FY 1985.

While the ICF-MR program has to some degree reflected the shift in programmatic philosophies toward community-based facilities, many contend that it also serves as a major impediment to the further realization of that

philosophy. About 80% of all ICF-MR payments still went to publicly-operated facilities in FY 1985. Many claim that States have a vested interest in keeping their State institutions operating due to: 1) political pressures from the State employee unions who staff the public institutions; 2) political pressures from those parents who believe that public facilities are the most "secure" component of the residential care system; and 3) the financial benefits to States of claiming ICF-MR reimbursement rates for their public facilities in excess of the direct cost of operating those facilities. In brief, existing reimbursement methodologies allow States to load substantial administrative and overhead costs on top of their direct operating costs for their public ICFs-MR, and also allow States to claim capital and depreciation costs which do not reflect real cash outlays. In other words, public ICFs-MR are often "Federal revenue generators." Advocates of community-based services therefore contend that States will refrain from closing their public institutions altogether without structural reforms to the ICF-MR program. In response, there have been legislative proposals, such as the Family and Community Living Amendments of 1985, which have proposed major changes in Federal financing incentives under the ICF-MR program for States to phase out their large-scale institutions over time, and invest these resources in community-based facilities and programs.

Opponents of these shifts in Federal financing incentives would prefer to see a more gradual development of the community-based delivery system. They point to a legitimate need to ensure that those clients who remain in publicly-operated ICFs-MR are adequately protected. Since most persons who remain in publicly-operated facilities are profoundly retarded, many of whom have concomitant physical and medical disabilities, community programs must be developed which can adequately meet their needs. While some States have clearly demonstrated the feasibility of developing quality community-based programs for severely disabled clients, most community-based programs have thus far served primarily the mildly and moderately retarded population. Thus, there are those who contend that the expansion of community-based programs must precede the closure of public institutions.

Another major policy issue concerns the actual definition of ICF-MR care itself. Medicaid service coverage policy has traditionally held that Medicaid

is limited to the coverage of "medically-oriented" services. There has been continuing friction between States and the Federal government regarding what services provided in the ICF-MR certified facilities are reimbursable under Medicaid and which are not. For example, ICF-MR regulations have specifically excluded Federal participation for "educational, pre-vocational, and vocational" services provided in an ICF-MR. There has been protracted litigation regarding what actually distinguishes "educational, pre-vocational, and vocational" services from "habilitative" services, which are reimbursable. Such distinctions become exceedingly difficult to make when it concerns toilet training a profoundly retarded client or teaching him to communicate with signs.

Thus, it is also contended that States should be given considerable more flexibility in determining what services can be provided to developmentally disabled clients within its State Medicaid plan. States have aggressively pursued Section 2176 Home and Community-Based Medicaid Waivers for the developmentally disabled, which permit such expansion in Medicaid service coverage, under certain fiscal constraints (Laudicina and Burwell, 1986). States have used Section 2176 waivers to cover a wide range of community-based services for the developmentally disabled outside of ICF-MR certified facilities, including case management, residential services, habilitative services, family counseling, respite care, transportation, and other services. However, there are concerns at the Federal level that such expansion in service coverage would lead to significant increases in aggregate Medicaid expenditures for the developmentally disabled, since only a minority of Medicaid-eligible developmentally disabled persons are currently served in ICF-MR certified facilities.

Another proposal for expanding State flexibility in providing services to the developmentally disabled has been to convert the ICF-MR program into a long term care block grant. As evident from the data presented in this chapter, however, a major impediment to the implementation of a block grant approach is in devising a block grant formula which would be equitable to all States. Given the wide variation in State expenditures for ICF-MR care, any formula is likely to yield big "winners" and "losers." If the formula is based on what States currently spend for ICF-MR care, States with high per capita expenditure

levels would be the winners, and States with low per capita expenditure levels would be losers. Alternatively, applying a population-based block grant formula (i.e. x dollars per 100,000 State population) would have the reverse effect--States with high per capita expenditures would be losers, while States with low per capita expenditures would be winners. While States may find the expanded service coverage flexibility under a block grant funding mechanism attractive, many would be wary that block grants would mean the end of Federal funding for the developmentally disabled as an entitlement. Guaranteed indexing of aggregate Federal expenditures under the block grant would be necessary to win State support.

In sum, the ICF-MR program is still used primarily as a means for States to gain Federal financial participation for the costs of operating their large publicly-owned institutions. Policy options have been advanced to shift a greater proportion of Medicaid resources from State institutions to community-based services and programs. However, a shift in Federal financing incentives towards community-based programs must address the needs of the approximately 100,000 persons who remain in State institutions. A key issue is how a community-based delivery system is to be financed--by redirecting existing Medicaid resources, or through an expansion in program benefits. At the same time, pressures are building to expand Medicaid services coverage for the developmentally disabled beyond the current restrictions of the ICF-MR program. There is likely to be increasing debate over the next few years regarding basic reforms to the ICF-MR program and Medicaid financing of services for the developmentally disabled in general.

TECHNICAL NOTES

1. The primary source for data presented in this chapter is annual statistical reports submitted to HCFA by State Medicaid agencies (HCFA form 2082 data). Given that data quality problems with HCFA 2082 data on ICF-MR recipients and expenditures were well known, considerable edits were made of the HCFA 2082 data files prior to analysis. External sources used in making these edits include HCFA 64 data, the Medicaid Tape-to-Tape data set, data collected in the course of La Jolla Management Corporation/ SysteMetrics evaluation of the Section 2176 Home and Community-based Medicaid waiver program, and many calls to the States themselves.

2. A few States require parents of developmentally disabled persons in State-funded facilities to contribute to the cost of care under State laws of general applicability. However, these contributions are collected outside the Medicaid eligibility process, and often apply to all children served in State-funded programs, not just Medicaid-funded programs. For example, California, which operates the most aggressive parental contribution program, collected almost $3 million from financially-liable parents in 1985.

3. Beginning in FY 1985, HCFA began requiring States to claim Federal matching payments for publicly-operated and privately-operated ICF-MR facilities separately. Data on public versus private expenditures for ICF-MR care prior to FY 1985 are not available.

Chapter 5 References

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Chapter 6

DISABLED RECIPIENTS OVER AGE 65

Analyses of aged and disabled Medicaid recipients are confounded by the fact that a growing proportion of recipients classified as "Disabled" by States are 65 years of age and over. Medicaid data on disabled recipients over 65 are therefore important for understanding the dynamics of Medicaid utilization and expenditure patterns within the SSI-related groups. The format in which States report Medicaid data to HCFA (HCFA form 2082) does not allow for special analyses of disabled recipients over age 65. The data presented in this study were obtained from the Medicaid Tape-to-Tape data base, which is condusive to special analyses of Medicaid populations by age group in a selected number of States. The data presented in this study are for disabled recipients over age 65 in Michigan, California and Georgia for 1983 and in New York for 1982.

Disabled Medicaid recipients over age 65 are persons who were originally eligible for Medicaid as disabled prior to reaching age 65, and who continue to be classified as disabled after passing their 65th birthday. Non-elderly disabled persons who receive SSI cash payments continue to be classified as disabled by the Social Security Administration once they reach their 65th birthday, and it appears that most State Medicaid agencies follow this practice as well for disabled recipients who receive SSI. For persons who do not receive SSI cash assistance ("non-cash" recipients), and in States which do not make all SSI recipients automatically eligible for Medicaid, classification practices get more complicated, and practices may vary considerably from State to State. But the most important point to keep in mind is that all disabled recipients over age 65 were also eligible for Medicaid prior to their 65th birthday. It is reasonable to assume that any person applying for SSI or Medicaid after reaching their 65th birthday is automatically classified as "Aged," since it would be highly inefficient to require such persons to go through the SSA disability determination process if they were already categorically eligible by age.

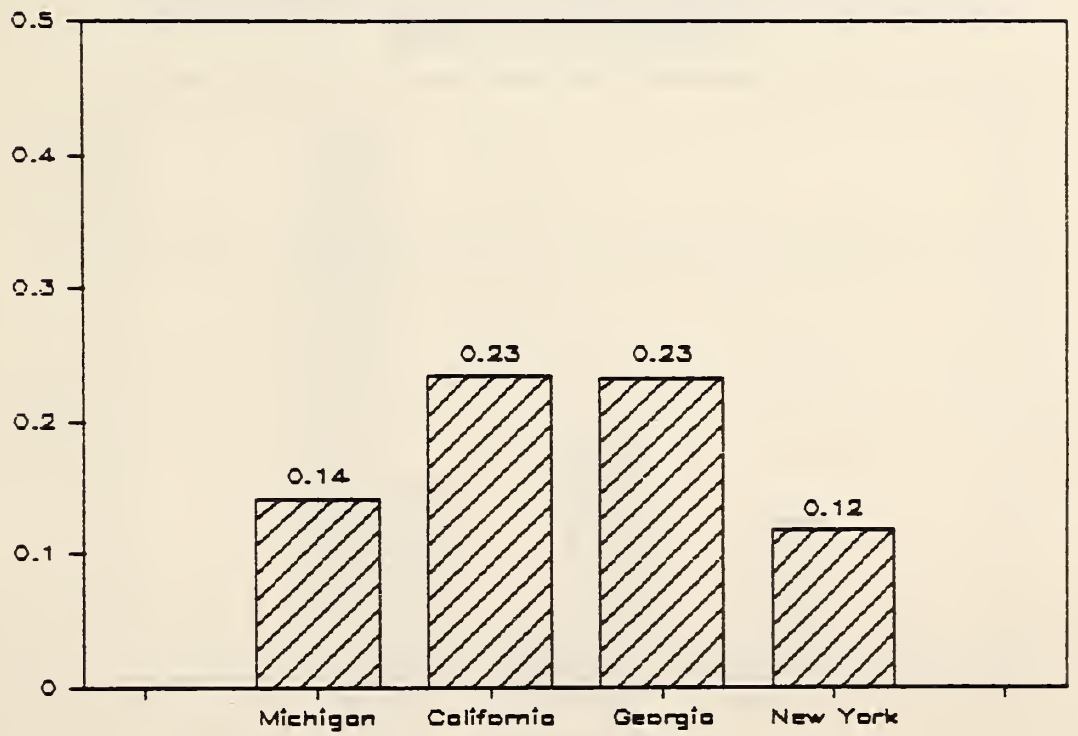
Characteristics of Disabled Recipients Over Age 65

Exhibit 6-1 presents the proportion of all disabled Medicaid recipients who were age 65 and over in the four study States. The proportion of disabled recipients who were over age 65 ranged from 11.7% in New York to 23.4% in California.

Disabled Medicaid recipients over age 65 differ from both non-elderly disabled recipients and recipients classified as "Aged" in significant ways. For one, the vast majority of the disabled over 65 still receive SSI payments, and are therefore classified as Medicaid "cash" recipients. Very few are eligible for Medicaid only (i.e. non-cash). Across the four study States, 94% of the disabled over 65 were cash recipients, compared to 83% of the non-elderly disabled, and only 64% of aged recipients.

Exhibit 6-1

Proportion of Disabled Medicaid Recipients Over Age 65



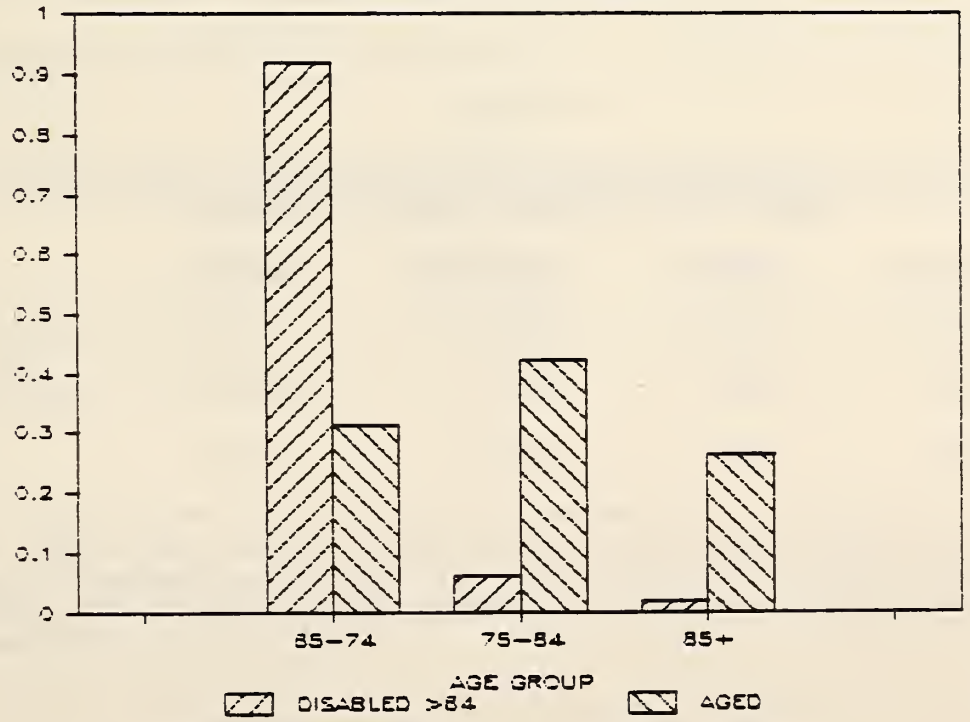
Source: Tape-to-Tape uniform enrollment files. All data are for 1983, except for New York, which are for 1982.

Second, compared to their non-elderly disabled and aged counterparts, disabled recipients over age 65 are less likely to be recipients of institutional long term care. In the four study States, only 7% of the disabled over 65 received institutional long term care, compared to 10% of the non-elderly disabled and 30% of the aged Medicaid population. However, we believe this finding is likely an artifact of State classification procedures. Since most SSI recipients who enter nursing homes lose their eligibility for SSI cash assistance (unless their income is below the SSI personal needs allowance), we believe that many disabled recipients over 65 who enter nursing homes are re-classified as "aged" by States once they no longer receive SSI cash payments.

Disabled Medicaid recipients over age 65 are also younger than their aged Medicaid counterparts, as shown in Exhibit 6-2. Over 90% of all disabled recipients over 65 were between the ages of 65 and 74, compared to only about 30% of the aged Medicaid population. This distribution was consistent across

Exhibit 6-2

Age Distribution of Aged Medicaid Recipients and Disabled Recipients Over Age 65



Source: Tape-to-Tape uniform enrollment files.

all four States. Again, this is primarily due to the fact that disabled recipients over 65 only include those persons who were eligible for Medicaid prior to reaching age 65 and continue to be eligible after reaching age 65. Since the SSI program was not enacted until 1974, a disabled Medicaid recipient who was 64 in 1974 would only be 76 in 1986.

Medicaid Expenditures for Disabled Recipients Over Age 65

Disabled recipients over 65 cost considerably less to Medicaid than non-elderly disabled recipients or aged recipients, as shown in Exhibit 6-3. They cost less than non-elderly disabled recipients because they are less likely to be institutional long term care recipients, except in Georgia, and because they were more likely to be also covered by Medicare, which reduces Medicaid costs. Further, even among the institutionalized disabled population, those over 65 cost less then the non-elderly disabled, since the elderly disabled were more likely to be receiving ICF or SNF care, while the non-elderly disabled were high utilizers of ICF-MR care, which is a much more costly Medicaid benefit. Disabled recipients over 65 are less costly than aged Medicaid recipients primarily because they are far less likely to be recipients of institutional long term care, as previously discussed.

Exhibit 6-3

Average Annual Medicaid Costs for Disabled Recipients Over Age 65, Disabled Recipients Under 65, and the Aged

	Michigan	California	Georgia	New York
Disabled ≥65	$2,415	$1,548	$1,959	$2,714
Disabled <65	4,820	3,779	2,993	6,329
Aged	4,486	2,209	2,545	6,804

Source: Tape-to-Tape uniform claims files. New York data include adjustments for Medicaid expenditures in publicly-operated ICF-MR facilities (which are not maintained on New York State MMIS system). All data are for 1983, except for New York, which are for 1982.

Among the non-institutionalized population, disabled recipients over age 65 remain less costly than non-elderly disabled recipients, but are more costly than aged recipients, except in New York. As shown in Exhibit 6-4, non-institutionalized disabled recipients cost between 49%-64% more than their non-institutionalized aged counterparts in Michigan, California and Georgia, and about 2% less than their aged counterparts in New York.[1]

Non-institutionalized disabled recipients over 65 are less costly to Medicaid than their non-elderly counterparts primarily because they are also eligible for Medicare. However, after controlling for institutional status and Medicare eligibility, average Medicaid costs for the disabled over 65 were still about 20% lower than average costs for the non-elderly disabled. This suggests that the elderly disabled may have different types of disabling conditions than the non-elderly disabled.

Exhibit 6-4

Average Annual Medicaid Costs for Non-Institutionalized Disabled Recipients Over Age 65, Disabled Recipients Under 65, and the Aged

	Michigan	California	Georgia	New York
Disabled ≥65	$1,056	$978	$1,150	$1,766
Disabled <65	2,369	2,265	1,852	2,773
Aged	645	644	773	1,793

Source: Tape-to-Tape uniform claims files. All data are for 1983, except New York, which are for 1982. New York data exclude expenditures for personal care services, which comprised about 30% of all non-institutional expenditures for the aged and disabled in 1982.

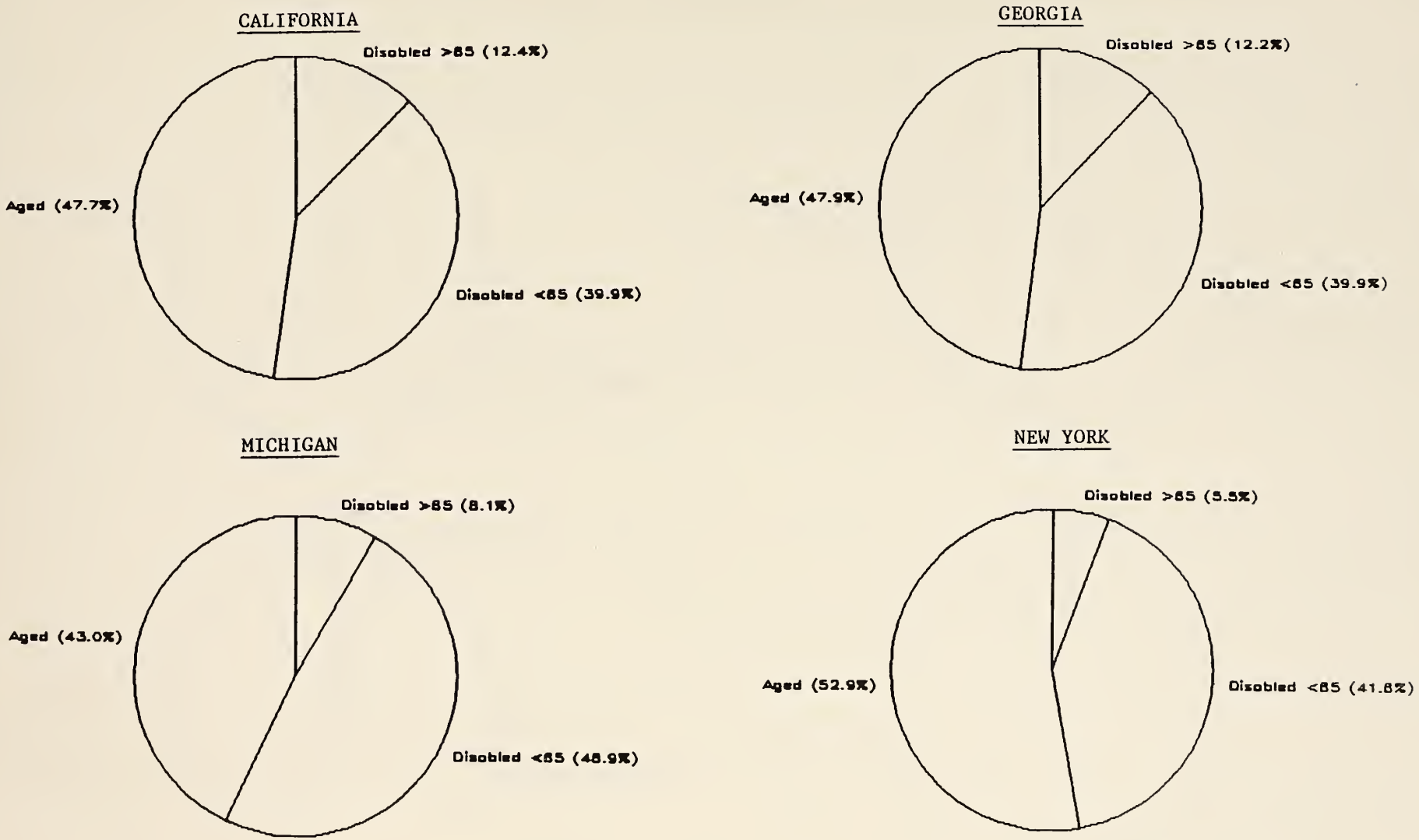
[1]Non-institutionalized recipients are defined as persons who used no ICF, SNF, or ICF-MR care during the study year. Non-institutional care expenditures in New York exclude expenditures for personal care services, which were not maintained on the State MMIS system in 1982.

In summary, the disabled Medicaid population over age 65 is largely comprised of non-institutionalized cash recipients between the ages of 65 and 74. Because such a small percentage of disabled recipients over age 65 are recipients of institutional long term care, they cost considerably less than the average aged Medicaid recipient. When institutional status is controlled for, disabled recipients over age 65 are more costly than their aged counterparts. Disabled recipients over 65 are less costly than non-elderly disabled recipients because: 1) a lower percentage are long-term care users; 2) of those recipients in long-term care, the elderly disabled are in less costly facilities (i.e. SNFs and ICFs as opposed to ICFs-MR); and 3) Medicare pays for a higher proportion of total costs for the elderly disabled.

One question of interest to policymakers is how the disabled over 65 affect the total distribution of Medicaid recipients and expenditures across the SSI groups. Exhibits 6-5 and 6-6 illustrate this effect in the four study States. If disabled recipients over 65 are included with the non-elderly disabled across all four States, the distribution of recipients would be 51% disabled and 49% aged. If disabled recipients over 65 are counted as aged, then the distribution would change to 41% disabled and 59% aged. Similarly, the distribution of expenditures across the two groups is 48.5% aged and 51.5% disabled if the disabled over 65 are counted as disabled. If they are included with the aged, the distribution of expenditures would change to 53.0% aged and 47.0% disabled. Put otherwise, counting disabled Medicaid recipients over 65 as aged rather than disabled would increase the aged Medicaid population by 19.8% but expenditures for the aged by only 9.2%.

Exhibit 6-5

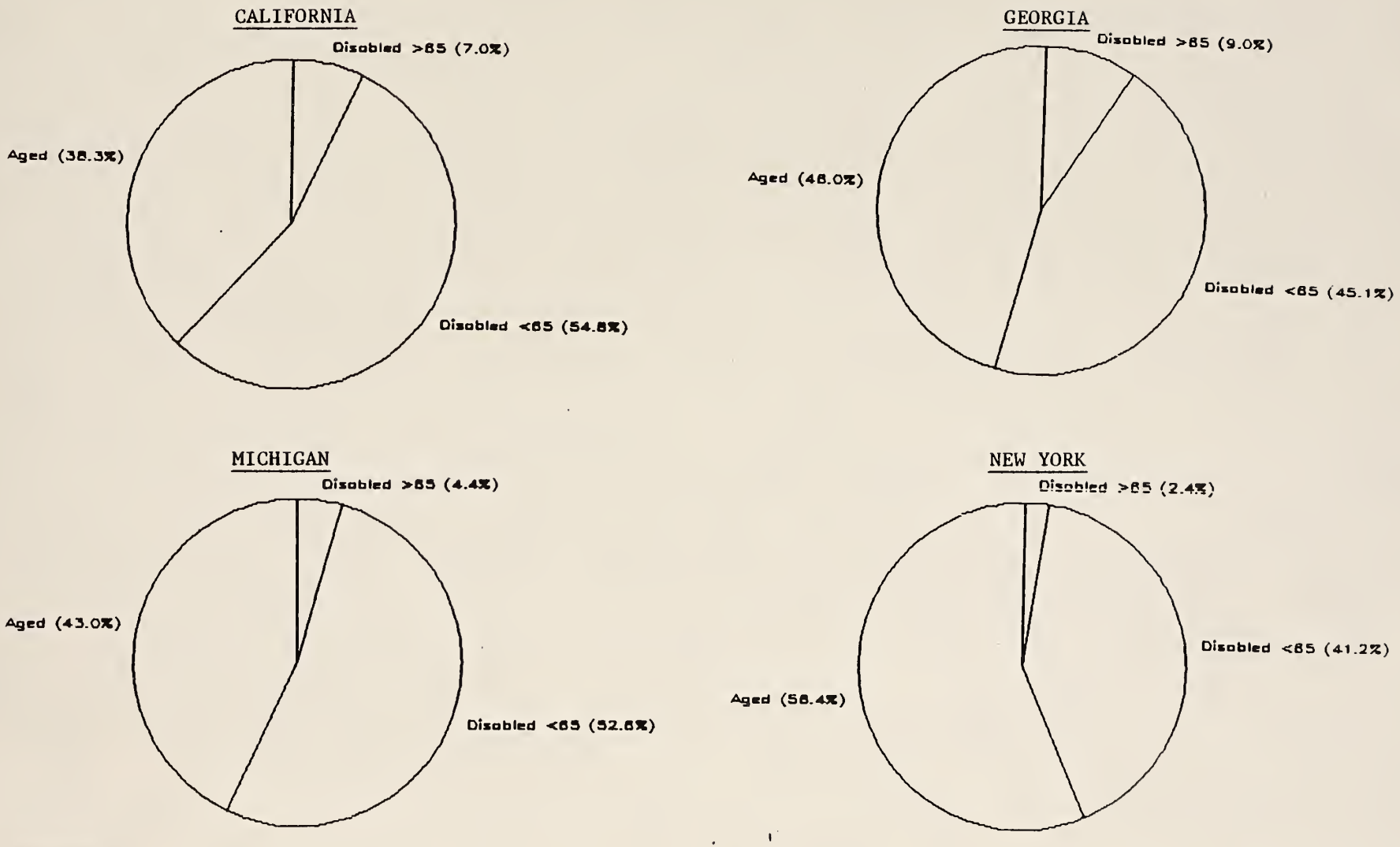
Distribution of Aged and Disabled Medicaid Recipients



Source: Tape-to-Tape Uniform Enrollment Files. All data are for 1983, except New York, which are for 1982.

Exhibit 6-6

Distribution of Medicaid Expenditures for Aged and Disabled Recipients



Source: Tape-to-Tape Uniform Claims File. All data are for 1983, except in New York, which are for 1982. New York data include adjustments for ICF-MR expenditures not contained on Tape-to-Tape files.

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